

**UNIVERSITY OF WINCHESTER**

New contracts, old problems: the unforeseen impact of  
indirect discrimination on NHS doctors

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Professional Doctorate by Contribution to Practice

July 2018

This Context Statement has been completed as a requirement  
for a postgraduate research degree of the University of Winchester

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**Key words** (up to 10 keywords – ask your supervisory team for advice):

Critical HRM, discrimination, employee relations, employee voice, HRM practices, power relations.

**Abstract:**

My Thesis, comprising my Context Statement and Published Works, presents my contribution to practice, scholarship and knowledge as an experienced Human Resource Management practitioner-academic. This study has integrated further my professional and academic selves (sic) and enhanced my academic identity, by conceptualising my learning and experiences into a critically reflective narrative for my professional doctorate. I have contributed to knowledge through this study and my contribution to six co-authored government publications by the Review Body on Doctors' and Dentists' Remuneration. I am at the centre of this Employee Relations case study which focuses on a contemporary phenomenon within the real-life context of the NHS. Its purpose is to understand why SAS doctors were dissatisfied with aspects of their new contract that had taken several years to negotiate. My aim was to explain why many doctors were dissatisfied, and what problem(s) the new contract had failed to resolve. Utilising a strategy of action research, this study undertakes an interpretivist exploration of the complex phenomena, through the collection and analysis of qualitative data and document analysis; its findings highlight the existence of competing perspectives and multiple realities amongst the parties. My critical and reflective analysis reveals the hidden effect of power relations on HRM practices and its indirect effect on the employment relationship. The study concludes that power inequalities in the form of indirect discrimination exist around the variables of gender and race for this population; they are probably institutionalised and, in this study, are reinforced by the HRM process of career progression. Organisational change in the NHS to modernise the contract has not led to all the predicted gains for SAS doctors, but has maintained managers' control over a key discourse. My work contributes to practice through the identification of indirect discrimination in the career pathway for SAS doctors in the NHS. As a consequence, remedial actions were taken by the General Medical Council, Department of Health and others; but this emancipatory case study raises general awareness of the unforeseen impact caused by any HRM process that may have a disproportionate adverse effect on workers with a protected characteristic.

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## DECLARATION

No portion of the work referred to in the Thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

I confirm that this Context Statement is entirely my own work.

I confirm that I am co-author of the published works referred to in the Thesis which were produced in collaboration with the following:

The Office of Manpower Economics, and Secretariat for the Review Body on Doctors' and Dentists' Remuneration: Catriona Hunter and Cliff Wilkes.

The Members of the Review Body on Doctors' and Dentists' Remuneration from 2007-2012, as listed in each report.

The Chair of the Review Body on Doctors' and Dentists' Remuneration, Ron Amy MBE for the *Thirty-Seventh Report* (2008); the *Thirty-Eighth Report* (2009); the *Thirty-Ninth Report* (2010); the *Fortieth Report* (2012); and *Review of compensation levels, incentives and the Clinical Excellence Award Schemes for NHS Consultants* (2012).

The Chair of the Review Body on Doctors' and Dentists' Remuneration, Michael Blair QC for the *Thirty-Sixth Report* (2007)

From years 2008-2012, I confirm I was the Lead Member on the SAS doctors and made a substantial contribution to the work on SAS doctors. As one of seven DDRB Members (including the Chair), I also contributed to all others chapters and aspects of the published works from 2007 to 2012.

Statistical analysis published in the works was undertaken or commissioned by the Office of Manpower Economics, or supplied by the parties as Formal Evidence.

## **DEDICATION**

This work is dedicated to my loving parents,

Janet Rose and Frederick Roy Easterling.

Thank you for bringing me into this amazing world.



## ACKNOWLEDGEMENTS

My journey to the point where I could commence a doctorate and, indeed, complete it, is thanks to the inspirational and supportive people whom I have met in my life. My thanks go to the team who supported me: my Director of Studies Professor Pru Marriott and my Second Supervisor Dr Adam Palmer, for their respective expertise and generous encouragement; Professor David Birks for initially supervising me; and Professor Alan Murray for seeing the potential of these published reports, then guiding me with my application for the Professional Doctorate and ethics approval. My special thanks go to Lisa Harding who has been such a great support and so encouraging throughout. My grateful thanks go to Ron Amy MBE, who acted as my external referee and was the Chair of the Review Body on Doctors' and Dentists' Remuneration. His support and guidance gave me confidence to follow my instincts. My thanks to Cliff Wilkes and Catriona Hunter at the Office of Manpower Economics, for their invaluable assistance.

I wish to acknowledge people who have helped me to become the person I am today, as reflected in this work. My thanks to my friend and former colleague, Dr Mark Lowman, who supported me in my time of need. My thanks to Geoff Armstrong CBE, who saw my potential for public service and acted as my referee for the Review Body on Doctors' and Dentists' Remuneration. My thanks to my dear, late friend Alan Murgatroyd FCIPD, with whom I first discussed my doctorate so many years ago. Alan, I miss your wit, your insight and our wonderful conversations about the profession of Human Resources Management. I also wish to acknowledge the late and great Don Currie, who was my Human Resources Management tutor at Southampton Institute of Higher Education; Don, you had so many stories to tell and brought to life the *real* world of work. My thanks to my dear friend Richard Hamilton, who has supported me on the emotional journey that accompanies the completion of a doctorate. My grateful thanks to my colleague and friend Dr Roz Sunley; you encouraged me and lifted my spirits when needed. My special thanks to naval historian and former shipmate, the late Lieutenant Commander Roger Derrick; our long friendship was a constant joy. Finally, my thanks to my sister, Tammera Easterling, who is an exemplar of equality and fairness. You inspire me to do more for others!

**ABSTRACT**

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Professional Doctorate by Contribution to Practice

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My Thesis, comprising my Context Statement and Published Works, presents my contribution to practice, scholarship and knowledge as an experienced Human Resource Management practitioner-academic. This study has integrated further my professional and academic selves (sic) and enhanced my academic identity, by conceptualising my learning and experiences into a critically reflective narrative for my professional doctorate. I have contributed to knowledge through this study and my contribution to six co-authored government publications by the Review Body on Doctors' and Dentists' Remuneration. I am at the centre of this Employee Relations case study which focuses on a contemporary phenomenon within the real-life context of the NHS. Its purpose is to understand why SAS doctors were dissatisfied with aspects of their new contract that had taken several years to negotiate. My aim was to explain why many doctors were dissatisfied, and what problem(s) the new contract had failed to resolve. Utilising a strategy of action research, this study undertakes an interpretivist exploration of the complex phenomena, through the collection and analysis of qualitative data and document analysis; its findings highlight the existence of competing perspectives and multiple realities amongst the parties. My critical and reflective analysis reveals the hidden effect of power relations on HRM practices and its indirect effect on the employment relationship. The study concludes that power inequalities in the form of indirect discrimination exist around the variables of gender and race for this population; they are probably institutionalised and, in this study, are reinforced by the HRM process of career progression. Organisational change in the NHS to modernise the contract has not led to all the predicted gains for SAS doctors, but has maintained managers' control over a key discourse. My work contributes to practice through the identification of indirect discrimination in the career pathway for SAS doctors in the NHS. As a consequence, remedial actions were taken by the General Medical Council, Department of Health and others; but this emancipatory case study raises general awareness of the unforeseen impact caused by any HRM process that may have a disproportionate adverse effect on workers with a protected characteristic.

Keywords: Critical HRM, discrimination, employee relations, employee voice, HRM practices, power relations.

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## **CHAPTER 1. AN OVERVIEW OF THE STUDY**

This chapter will present my contribution to practice and scholarship, and the published works that form part of the submission. The work is set in the context of the public sector; the employer is the National Health Service (NHS); and there is particular focus on doctors and dentists, a group which forms the remit of the Review Body on Doctors' and Dentists' Remuneration. The specific population under scrutiny is the Speciality Doctors and Associate Specialists (SAS); a subgroup of secondary care senior hospital doctors.

### **1.1 My Contribution to Practice and Scholarship**

The Context Statement sets out how I made an original contribution to practice and scholarship as an experienced practitioner-academic in Human Resource Management. The context of my study is a Pay Review Body for NHS doctors. My overall aims were to explain why SAS doctors were dissatisfied with their new contract which had worsened, rather than improved, their morale; and to identify what problem(s) the new contract failed to resolve, and why.

My contribution to practice is the illumination of a critical reason for the longstanding dissatisfaction of SAS doctors with their career progression; namely, the identification of indirect discrimination in the career pathway for SAS doctors in the NHS. This identification resulted eventually in the parties' return to dialogue, and actions taken by the General Medical Council, Department of Health and others to remedy the inequality within the career progression process. This contribution is the result of my sustained work in the field of Employee Relations, with a particular focus on the interdependents of Employee Voice and Discrimination, and the underlying power relations inherent in these areas. My study highlights the importance of acknowledging the competing perspectives and multiple realities of all parties, if an employment relationship is to be mutually beneficial (Kaufman, 2015).

This interpretive study provides an important contribution to knowledge through my use of qualitative research to deconstruct and reveal the often invisible, but no less real, complexities of power relations within HRM and its practices. These

are complex issues related to inequitable practices, unjust structures and dominant barriers (Fenwick, 2005:235). My case study's identification of indirect discrimination denaturalises organisational power; furthermore, it highlights the managerial perspective with which HRM continues to align itself (Legge, 2005; Delbridge and Keenoy, 2010). Changes to the SAS doctors' contract resulted in immediate gains for management interests (i.e. an increase in working hours) but a painfully slow assimilation over years for some of the espoused gains (i.e. increased pay, professional development and career progression) for the SAS doctors. Most importantly, the career progression route was unlikely to ever deliver, as independent secondary data confirmed that the practice indirectly discriminated against the SAS doctors, who predominantly possessed the legally protected characteristics of female gender and race. The insights from my research that can be applied from this practice-based research are that power inequalities in the form of indirect discrimination exist around the variables of gender and race; they are probably institutionalised (Delbridge and Keenoy, 2010) and, in this study, are reinforced by the HRM process of career progression. Organisational change to modernise the NHS has not led to all the espoused gains for SAS doctors but has maintained managers' control over a key discourse that has implications for their power (Brookfield, 2005; Diefenbach *et al.*, 2009).

Improved career development opportunities had been a key aspect of the new contract negotiated between the British Medical Association (BMA) and the National Health Service Employers (NHSE). My investigation revealed that, at a particular stage of a mandatory process known as a Certificate of Eligibility for Specialist Registration (CESR) under Article 14, the career pathway for SAS doctors had been limited rather than enabled. The new contract and NHS reform was based on the policy *Modernising Medical Careers* (Department of Health, 2004). My findings reveal fewer SAS doctors were successful in their application for CESR (and entry to the Specialist Register) than other groups of doctors who had several routes to the Specialist Register. It is a mandatory and legal requirement that doctors are *only* eligible to apply for a consultant post when they are placed on the Specialist Register. One in three CESR applications by SAS doctors was unsuccessful. This resulted in a significant lack of career progression, which had unforeseen consequences on their career development, their remuneration and, as a consequence, their job satisfaction and morale.

My study looked at variables, such as the protected characteristics of the group: age, gender, and ethnicity or race (often used interchangeably). The SAS group has a large number of females; as well as men and women with a Black, Minority Ethnic (BME)/Black, Asian, Minority Ethnic (BAME) background (*Institute of Race Relations*, 2017 [online]). My practitioner expertise enabled me to deduce that access to only *one* career progression pathway was discriminating indirectly against these doctors. The sole career pathway specified for them – CESR – had a *disproportionate adverse effect* on these doctors, as specified in the *Equality Act 2010* (2010 [online]). I found evidence to substantiate that a large proportion of SAS doctors who had the protected characteristic of race and/or gender were more likely to be unsuccessful in their applications for CESR. This prevented a significant number of SAS doctors from being placed on the Specialist Register. Consequently, they were unable to apply for a consultant post. I sought to bring about change so that the parties would agree to go back to formal talks and find a solution to this problem.

Because of previous impasses and cessation of pay talks between the parties, this was a formidable goal. In 2007, the government, Department of Health (DoH) and National Health Service Employers (NHSE), had claimed that the Review Body on Doctors' and Dentists' Remuneration (DDRB) no longer had a role to play in the setting of pay for General Practitioner (GP) doctors. This followed the introduction of the new General Medical Services (GMS) contract for GPs; a part of the modernisation agenda. This claim was in direct opposition to the views of the NHS doctors' trade union, the British Medical Association (BMA). Furthermore, the government had imposed staged pay awards on public sector workers. For the next two years after I was appointed, the political and industrial relations climate was extremely challenging for the independent Review Body on Doctors' and Dentists' Remuneration (DDRB).

The NHS is the largest organisation in the UK and is extremely complex. It has statutory, legal and governance obligations related to its clinical work, in addition to its legal and professional responsibilities as an employer. Its work is impacted by the Department of Health, the General Medical Council and many other bodies.

## 1.2 My Rationale for Undertaking this Doctorate

It has been my long-held ambition to complete a doctorate. However, starting such an epic undertaking was the real challenge. I now know there is never a *good* time; it is a leap of faith. In 2003, I contacted the former King Alfred's College of Higher Education, to discuss doctoral programmes. My journey led eventually to a Senior Lecturer role at the (now) University of Winchester. Along the way, I have taken side-roads which have strengthened this doctorate. For example, my coaching and mentoring qualification has enabled me to understand critical reflection, reflexivity and the study of oneself; becoming a trade union representative for the University and Colleges Union (UCU) has given me a hands-on experience of collective bargaining.

In 2014, my Head of Department asked if I had any publications. I gave him a pile of DDRB reports that I had co-authored. He passed them to the Head of Research, Knowledge and Exchange who was astounded at the impact of these works. A discussion about a doctorate started there; initially as a PhD by Works in the Public Domain which then metamorphosed into a Professional Doctorate by Contribution to Practice. I was surprised and had not appreciated the academic value of these works. To me, it was just something that I had done; like many things in my life, I just do it and I am low key about my contribution. I like to be of service; I enjoy sorting out complex issues and I want to ensure that people's lives are just and humane. I have the good fortune to have useful skills, knowledge and experience and, therefore, I want to put myself to good use in the world. I have strong beliefs and values that guide me. These have been shaped by my upbringing, my family, my experiences and my profession. Most people would say I have a strong sense of justice; moreover, I have a deep compassion for people, for animals and for the environment. I view the world as a complex, inter-dependent entity; looking after the ill, the weak or the oppressed is a responsibility that I embrace; I feel a genuine responsibility to share my good fortune and to help others.

### 1.3 The Published Works

My co-authored published works in the form of government publications span the years 2007 to 2012. The full works are set out in Appendix 8, and listed below:

Table 1.1 Published Works

Date	Published Work	Reason	Scope
2007	Review Body on Doctors' and Dentists' Remuneration (2007) <i>Thirty-Sixth Report</i> . Norwich: TSO.	Independent Pay Review Body (DDRB)	All UK NHS Doctors and Dentists
2008	Review Body on Doctors' and Dentists' Remuneration (2008) <i>Thirty-Seventh Report</i> . Norwich: TSO.	Independent Pay Review Body (DDRB)	All UK NHS Doctors and Dentists
2009	Review Body on Doctors' and Dentists' Remuneration (2009) <i>Thirty-Eighth Report</i> . Norwich: TSO.	Independent Pay Review Body (DDRB)	All UK NHS Doctors and Dentists
2010	Review Body on Doctors' and Dentists' Remuneration (2010) <i>Thirty-Ninth Report</i> . Norwich: TSO.	Independent Pay Review Body (DDRB)	All UK NHS Doctors and Dentists
2012	Review Body on Doctors' and Dentists' Remuneration (2012), <i>Fortieth Report</i> . Norwich: TSO.	Independent Pay Review Body (DDRB)	All UK NHS Doctors and Dentists
2012	Review Body on Doctors' and Dentists' Remuneration (2012) <i>Review of compensation levels, incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants</i> . Norwich: TSO. **	Invitation made in 2010 by Secretary of State for Health on behalf of the United Kingdom Health Ministers to commission a UK-wide review of compensation levels and incentive systems and the various Clinical Excellence and Distinction Awards schemes for NHS Consultants at both national and local levels.	UK-wide review (England, Wales, Scotland and Northern Ireland) of NHS Consultants at both national and local levels.

**\*\* Although this government report does not directly contribute to the study, it demonstrates my wider contribution to practice and the breadth of my work.**

#### 1.4 Introduction to the Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was first appointed in July 1971. Its terms of reference were introduced in 1998; then amended in 2003 and latterly in 2007 (Review Body on Doctors' and Dentists' Remuneration, 2012a:iii). The Review Body's role is to give independent advice and recommendations on the pay of doctors and dentists employed in the NHS. The pay bill for this group of workers was approximately £15.1 billion in 2006; therefore, its recommendations could have considerable economic impact for the NHS and, consequently, the governments of the United Kingdom (UK).

In making its recommendations, a Review Body must take into account evidence from the *parties*: the employer, the unions which represent employees, and the government. There is an expectation that the government will honour any recommendations made by a Review Body and, therefore, the employee representative union(s) will not pursue any form of industrial action. There are currently eight Pay Review Bodies that collectively have a pay bill of £100 billion and cover 2.5 million workers, i.e. 45% of public sector workers (*Office of Manpower Economics*, 2018 [online]). The Secretariat is provided by the independent Office of Manpower Economics (OME). The Review Bodies comprise: The Armed Forces Pay Review Body; The NHS Pay Review Body; The Prison Service Pay Review Body; The School Teachers' Review Body; The Senior Salaries Review Body; The Police Remuneration Review Body; The National Crime Agency Remuneration Review Body and, the focus of this study, The Review Body on Doctors' and Dentists' Remuneration (DDRB).

The recommendations on pay from the DDRB are submitted jointly to the Secretary of State for Health; the First Minister and the Cabinet Secretary for Health, Wellbeing and Cities Strategy of the Scottish Parliament; the First Minister and the Minister for Health and Social Services in the Welsh Government; and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive and the Prime Minister (Review Body on Doctors' and Dentist' Remuneration, 2012a:iii).

The remit for the Review Body on Doctors' and Dentists' Remuneration is as follows:

'In reaching its recommendations, the Review Body must have regard to the following considerations:

- the need to recruit, retain and motivate doctors and dentists;
- regional /local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;
- the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues. It is also required to take careful account of the economic and other evidence submitted by the Government, staff, professional representatives and others.

Finally, it should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability' (Review Body on Doctors' and Dentists' Remuneration, 2009:iii).

The final paragraph outlining the legal obligations of the Review Body was added formally in July 2007 prior to the commencement of the 2008/9 Pay Round, but is of particular relevance to my research (see Appendix 1).

## **1.5 The Phenomenon under Investigation**

A group of doctors, known as Staff and Associate Specialists (SAS), was being taken through a much delayed and drawn-out change to contractual arrangements. The negotiations had started in late 2004, before I was appointed to the DDRB. The staff group was originally known as *Staff and Associate Specialist/Non Consultant Career Grades (SAS/NCCGs)* but under the new contract, it changed to *Staff and Associate Specialist (SAS)*.

The main parties in the negotiations were the British Medical Association (BMA), the National Health Service (NHS) represented by National Health Service Employers (NHSE), and the former Department of Health (DoH) which is now the

Department of Health and Social Care. The BMA is the professional association and registered trade union for all United Kingdom doctors and, therefore, the employee representative for this group of doctors. The NHSE represented the doctors' employer, the NHS. The role of the DoH was to approve the new contract agreed between the BMA and NHSE, and present it to the Public Sector Pay Committee. The DoH is a department of government which acts as the policy-maker for health (and now, social care). It oversees the NHS in liaison with other medical bodies such as the General Medical Council, the Deaneries and the Postgraduate Medical Education and Training Board.

Consultants, Junior Doctors, Dentists and General Practitioners had finalised new contracts; the SAS staff group was the last. The process for SAS doctors had been lengthy and subjected to delays (see Appendix 5). Formal negotiations between the two parties lasted eighteen months and an agreement was reached finally in 2006; however, it was claimed the DoH subsequently held up approvals of the new contract. Only in December 2007, did the Treasury release the new contract, which then was subjected to a staged implementation process, starting 1 April 2008. In 2008, the BMA advised in its formal oral evidence that:

'morale among this group was very low [and] 'delays to the contract, transitional impositions and frustration at the failure of the new contract to deliver all that was required for the grade... [and] had all led to a very low level of morale in the SAS grades' (Review Body on Doctors' and Dentists' Remuneration, 2008:95).

At the heart of the new contract were: the creation of new grades (Speciality Doctor and a new Associate Specialist grade) and, the establishment of an explicit career pathway. The old Associate Specialist grade would close to new applicants. The transition to the new contract did not run smoothly and issues quickly surfaced. These were related mainly to career progression and, therefore, impacted pay. It is these issues that I have investigated.

## **1.6 Structure of the Context Statement**

The Context Statement for this Professional Doctorate commences with chapter one, which introduces the phenomenon under investigation, explains my rationale for undertaking a doctorate, and gives an overview of the document.



Chapter two outlines my credentials and career in Human Resource Management (HRM), and my values. Chapter three clarifies my research aims and questions. Chapter four focuses on the theoretical context and the literature directly relevant to my study. Chapter five reflects on my research philosophy and methodology. Chapter six discusses the context of the study and my findings. Chapter seven explains the impact and contribution my work has made to professional practice, and sets out the scholarship aspects and my contribution to the body of knowledge. The final chapter draws together my conclusions in relation to the literature and presents my overall reflections on my research and autobiographical journey. I have followed the University of Winchester Guide to the Harvard System of Referencing (Johnson and Jones, 2017).

The importance of my autobiography is central to this Context Statement since it delivers a critical insight into my practice (Brookfield, 1998 and 2014). It has enabled me to observe, listen, enquire and make sense of a complex phenomenon overlooked by the DoH, NHS and other important bodies. The process of creating this work has enabled me to develop further my research practice, critical writing and reflexivity. Eastman and Maguire (2016) highlight the importance of critical autobiography to students who undertake a professional doctorate. Therefore, I have aimed to reconceptualise my learning and experiences into a professional narrative which illustrates the beneficial impact of my work on others; people that I do not know personally but whom my work has helped. This educational journey has required me to reflect how my values and academic identity integrate with significant events that have been part of my professional life. This work has been a vehicle to integrate further my professional and academic selves (*sic*); in retrospect, it has brought the two closer together and enhanced my academic identity.

## **CHAPTER 2. MY JOURNEY AND CONTRIBUTION TO THE FIELD OF HUMAN RESOURCE MANAGEMENT**

In this chapter, I present an overview of my background and professional expertise that has guided my life. This chapter sets out the contribution I have made: my engagement with my professional institute, my work experience and qualifications, my contribution to public service, my values, discrimination I have encountered personally, and how I came to be appointed to the Review Body on Doctors' and Dentists' Remuneration.

### **2.1 My Professional Qualifications**

This Thesis represents a professional, research and publication pathway from 2007 to 2012. I have a professional background in HRM at a strategic level and almost 30 years' HRM experience. I am a Chartered Fellow of the Chartered Institute of Personnel and Development.

In 1991, I completed my Postgraduate Diploma in Personnel Management at the Southampton Institute of Higher Education. I sat the Institute of Personnel Management's (IPM) national examinations and achieved a Distinction in Resourcing, which was awarded only to 1.5% of students. In 2000, I completed a Master of Science (MSc) in Human Resource Management at Sheffield Business School. In 2004, I was awarded a Postgraduate Advanced Certificate in Coaching and Mentoring from Oxford Brookes University and the Chartered Institute of Personnel and Development, in conjunction with the Oxford School of Coaching and Mentoring. In 2013, I completed a Level 1 course entitled *Trade Unions Today*, credited by the College of Haringey, Enfield and North East London. In addition, I hold other profession-related awards.

### **2.2 Contribution to my Professional Institute**

In 1989, when studying for Stage I of my professional qualification at the Gloucestershire College of Arts and Technology, I was invited by the Gloucestershire branch of the Institute of Personnel and Management (IPM) to become the Student Representative on the Branch Committee. Although I

completed Stage II with the Southampton Institute of Higher Education, I remained with the Gloucestershire branch and volunteered for many committee roles. I co-organised many successful events, ranging from conferences to the annual branch programme; in 1994, at the young age of 33, I was elected the Branch Chair. When the IPM merged with the Institute of Training and Development to become the Institute of Personnel and Development (IPD), I was invited to serve on its National Council.

In 1999, I stood successfully for election as a Board Member and Trustee of the IPD's Executive Board; at the time, I was advised that I was the youngest person to have been appointed to this role. I was re-elected in 2003 and served the maximum two terms until 2006. During this period, I was part of the team which successfully applied, through the Privy Council, for a Royal Charter to be granted to the Institute. This was granted in July 2000 and the Institute became the Chartered Institute of Personnel and Development (CIPD). A further application granted the CIPD the power to confer individual Chartered status on its Members and Fellows, from 2003 onwards. My name is inscribed on the CIPD's magnificent Charter which confirms its Chartered status. From 2006 to 2009, I contributed as a Member of the CIPD's Faculty of Management which acted as a think tank for the development of training and qualifications in Management; more recently, I was a Member of the CIPD's Disciplinary Board which hears cases pertaining to the Institute's Professional Code of Conduct. All the above was voluntary work for my professional Institute.

### **2.3 Contribution to Public Service**

I have volunteered throughout my life to serve my local community, my professional Institute and my country. Below are some highlights:

From 1988 until 1997, I served as a Commissioned Officer with the Royal Naval Reserves achieving the rank of Sub Lieutenant. I was one of the first females to serve on-board a minesweeper, after the Queen's Regulations Royal Navy (QRRNs) changed to allow women to work in sea-going roles. I served in the Seaman branch of the Mine Counter-Measures Squadron.

In 2002, I was offered my first Public Appointment, as a Non-Executive Director of the Newbury and Community Primary Care Trust. Unexpected commitments prevented me from formally accepting the appointment but, in line with my values, I offered to contribute in a voluntary capacity. This experience, between 2002 and 2005, enabled me to develop a deeper understanding of the NHS, which proved advantageous later with the DDRB.

I have held two Public Appointments which have utilised my HRM expertise for public service. The first in 2004, when I was appointed by the Lord Chancellor as an Independent Panellist to the Department of Constitutional Affairs, which subsequently became the Judicial Appointments Commission (JAC) in 2006. The JAC's role was to implement changes contained in the *Constitutional Reform Act 2005* (2005 [online]). I served for eight years to, firstly select and recommend the highest calibre of candidates for appointment to the judiciary and, secondly, to encourage diversity in those suitable for appointment (Judicial Appointments Commission, 2008). A letter from the JAC's Chief Executive Officer outlines my 'significant contribution' (see Appendix 2).

The second in 2006, when I was appointed by Lord Warner, Minister for Health, to the Review Body on Doctors' and Dentists' Remuneration (DDRB). The DDRB has seven members, including a Chair. In 2010, Members of the DDRB were invited by the Secretary of State for Health to undertake a review of compensation levels, incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants. It was a significant review and our Report (Review Body on Doctors' and Dentists' Remuneration, 2012b) was laid before Parliament in 2012 (HC Ministerial Statements 17 December 2012). I was re-appointed by the Minister of Health and served the maximum two terms (see Appendix 3).

## **2.4 My Professional Background**

I have worked in the field of Human Resource Management (HRM) since the late 1980s. In 1991, I qualified as an HRM practitioner and then worked in generalist HRM and HR information systems roles, before moving into the specialist area of pay and remuneration in 1994. My industry experience includes shipping, oil and the health and medical sector. I worked for ten years for some of the world's

leading pharmaceutical, biotechnology and medical devices companies. I joined Bayer plc in its UK Pharmaceutical Division from 1994 to 1998, as a Human Resources Adviser. As its pay and remuneration specialist, I was responsible for the division's salary surveys programme and was the HR lead for the annual salaries budget and forecast. I represented Bayer at the Pharmaceutical Exchange Group: a UK remuneration network for the top 15 pharmaceutical organisations. In 1997, my responsibilities were extended to include the Stoke Court Research Facility in Buckinghamshire. This facility employed approximately 60 world-leading scientists.

At the end of 1998, I joined Guidant (a former subsidiary of Eli Lilly) as an International HR Manager looking after the UK, Nordic, Eastern Europe and Europe, Middle East and Africa (EMEA) countries. Guidant was the world's No. 2 in its field and specialised in cardiovascular and vascular products, such as stents, defibrillators and pacemakers. I had responsibility for international remuneration which included the implementation and management of a global stock options scheme in my geographic areas. I was the lead HR manager for a successful relocation of staff in Sweden (from Malmö to Stockholm). The closure of the Malmö facility required statutory liaison with the local trade union and participative collaboration with our workers. This experience developed my understanding of the importance of collaborative employee relations to achieve change successfully and with mutual benefit. Guidant had an excellent management development programme: one of my highlights was spending three hours working with Professor David Ulrich. In 2000, I became HR Director of Vernalis plc, a FTSE 250 biotechnology company. I moved to Hollister in 2001 as its Head of Human Resources for EMEA. An American global, medical devices business with sales of £410m, Hollister was a world-leading colostomy product manufacturer and distributor. At the end of 2003, I started my portfolio career.

## **2.5 My Portfolio and Academic Careers**

In 2003, I was invited to guest lecture for the then King Alfred's College of Higher Education, after telephoning to discuss doctoral programmes. I combined this voluntary activity alongside my portfolio HR career.

In later years, I was offered a part-time, fixed-term contract which later became a part-time permanent contract. I work currently at the University of Winchester as a Senior Lecturer in HRM for the Winchester Business School, in the Faculty of Business, Law and Sport. I have experience as an External Examiner in postgraduate and undergraduate HRM programmes with four British universities.

I am an elected Trade Union Representative for the academic staff union, Universities and Colleges Union (UCU), and it is a role that I still hold. Through experiential learning, developmental courses and first-hand experience, this role has enhanced my understanding of collective bargaining processes. My earlier experiences of HRM practice have sensitised me to the value of listening to the 'employee voice' (Kaufman 2015:19) as a valid means of communicating employees' concerns and issues to the employer organisation. I designed and now lead an applied undergraduate module entitled *Employing People*. It has an experiential assessment in which each student spends a day at an Employment Tribunal; then writes a critical reflection on his or her experience, and how it relates to the multiple perspectives of the employment relationship.

## **2.6 Personal Values as a Human Resources Professional**

I have worked for nearly 30 years in the field of HRM and, during that time, I have developed a particular stance with regard to my beliefs and approach to the management of people. As a practitioner, I believe that workers and employers have common interests which can and should unite them; therefore, it *is* possible to have a unitary perspective on the employment relationship. This approach emphasises individualism, high commitment and the alignment of HR strategy with business strategy. Furthermore, it recognises employees as valuable *assets* which make up a unique organisational capability for competitive advantage, rather than a mere cost or overhead to the organisation (Storey, 2007).

However, I recognise and respect the reality that a pluralist perspective exists in many organisations, as there are differing interests in the employment relationship. This may bring about conflict that is best channelled and managed through formal institutions such as trade unions. My experience in the workplace has corroborated that the radical perspective is very much alive and well;

employment relations can mask the reality of unequal power and exploitation of workers (Fox, 1974). This is not limited to unskilled or semi-skilled workers, but extends to professional or knowledge workers whose allegiance and, sometimes, devotion to their profession enables exploitation by capitalist employers.

*The Information and Consultation of Employees Regulations 2004* (2004 [online]) symbolise the legislative enshrinement of my values: namely, workers should be collaborative partners in the organisation; they are to be informed and consulted about matters that involve their work, security and organisation. I believe work should be humane and just. Collaboration in the employment relationship may bring about conflict; as McNiff notes 'pluralism does not necessarily mean trying to reconcile conflicting views, but means engaging with conflict' (McNiff, 2002:3). In other words, we may agree to disagree but at least we have had the discussion. Debate, listening, open meetings, surveys, collective bargaining, staff associations; all are valid mediums for dialogue between employee and employer.

When I worked in healthcare, my organisations employed highly-skilled and highly-educated professional employees. From 1994 onwards, I specialised in providing an HR service to world-class scientists and medics. This began an interest in what I perceived from my practice to be an emerging phenomenon: the *knowledge worker* (Stewart, 1998). The dissertation for my MSc was entitled 'An investigation into the HR issues that managers may face with the emergence of the knowledge worker' (Easterling, 2000). This research studied HRM practices that were of particular significance to management of the knowledge worker; career progression and reward were highlighted as key motivators for this type of worker. My dissertation concluded that participative employee relations are critical to a successful relationship between the knowledge worker employee and employer. Doctors are knowledge workers and fit into the Network and Expert quadrants of Frenkel *et al.*'s (1999) Model of Work.

The completion of a Postgraduate Certificate in Coaching and Mentoring in 2004 further underpinned my interest in the coaching process, with the use of critical reflection and a linguistically rich approach (Fillery-Travis and Cox, 2014:453) to facilitate inquiry. From that time onwards, it has been a key element of my

professional practice and was central to the discoveries that I made on my journey of learning for this study.

## **2.7 Appointment to the Review Body on Doctors' and Dentists' Remuneration**

I was appointed to the DDRB in 2005 (for the 2006/7 Pay Round). It followed an intense interview by a panel. One question I remember well, related to *independence*. I was asked specifically about my independence, and I remember my reply which was suitably phrased, revealing I was not one to compromise when values and *doing the right thing* were at stake. At first, I thought I had been too forthright but it proved my sincerity and independence. In 2009, it was noted in my feedback from the DDRB's Chair, that I had a unique way of looking at the world. In terms of constructive challenge I 'came up with challenges to the majority view' and 'often raise[d] issues and challenges that others have not considered' (Amy, R. (2009) E-mail with document attached to Katrina Easterling, 7 September). This feedback further emphasised that I was considered by third parties to be critically reflective and independent in my thinking and actions. It was this independence of thought that enabled me to develop my thinking and consider alternative views of the issues for SAS doctors, when others did not. I brought my sense of fairness and justice to this role; and I believe that I was the first CIPD qualified practitioner to join the DDRB.

## **2.8 Forms of Discrimination Encountered**

Discrimination is core to this work, and I have encountered many forms. My gender is female and that adds an additional lens through which I view and interact with the world (Huisman, 2008). Below, I have set out two examples of my first-hand experience of discrimination:

### **2.8.1 Example One**

I was one of the first females to serve on Royal Navy ships in the early 1990s, when the QRRNs changed to allow women to work at sea. I encountered scepticism, welcome, distrust and direct discrimination. One Commanding Officer (CO) was even prepared to sail short of officers rather than have 'some bloody woman on my ship' – I heard his ranting as I stood outside his cabin. The CO I had



served for the previous two weeks, had attempted to explain what an exemplary job I had done on the Continuous Training Period; that I was volunteering to stay in order to complete my training as a qualified Officer of the Watch, as well as to help a ship that would otherwise sail under-manned. It upset me because, firstly, his decision prevented me from completing the requisite hours for my Officer of the Watch Certificate and, secondly, it was subjective: not about my ability but about my *gender*. Reasoned argument was ignored because he was the dominant power.

### **2.8.2 Example Two**

Whilst working in organisations, I have seen unfairness and discrimination towards a variety of employees. One example relates to the UK Research Division of a multi-national pharmaceutical company which had 48,000 employees worldwide. In 1997, the Division employed over 60 scientists, but it would lose female staff who needed to come back to work part-time instead of full-time, after maternity leave. The Research Director imposed a 'full-time or no-time' approach. It was costing the Division well trained and highly motivated staff in a global, competitive industry.

I decided to discuss the issue with the Research Director when the next maternity leave occurred. The employee was an excellent scientist; she was working on a critical project and had skills which I knew would be extremely hard to replace. Before she returned from maternity leave, I raised the matter with the Director (having ascertained the employee's wishes before she went on maternity leave that she wanted to come back on a part-time basis). In summary, I put forward a convincing argument that he had nothing to lose from trialling her as a part-time employee. I proposed that if it did not work out, he could offer her the usual terms of 'full-time or out'. With nothing to lose, he agreed and the employee returned. I had advised her how important this trial was; not only would it be personally significant to her, but also to every other female employee who wished to work part-time in the future. It worked perfectly well, as I had anticipated; the Research Director was very happy, as was the employee. With the Research Director's fears and bias around part-time working dissipated irretrievably, she was the first of many women to work part-time after maternity leave. This change in his attitude lowered staff turnover and retained key skills.

Later, I introduced a policy to clarify the process for Request for Part-Time Work for Maternity Leave Returners; the policy was accepted subsequently throughout the Division. Much later, legislation was introduced in the United Kingdom to enshrine these rights for workers in *The Part-Time Workers (Prevention of Less Favourable Treatment) Regulations 2000* (2000, [online]). It had seemed a waste of talent, and unnecessary effort to recruit and replace skilled staff; furthermore, it was an unfair practice against women, although it was still legal in 1997.

## 2.9 Summary

My personal values have guided me through my corporate and academic careers. I believe that they were central to my Public Appointments, and in making my contribution to society. As a woman, I have seen third-party discrimination and suffered it personally. As a Human Resources professional, I genuinely wanted, and still want, to ensure that organisations and society are fair places in which the only discrimination is on grounds of ability. I have been very fortunate to find myself in influential positions where I could make a difference. This does not mean it has been easy; sometimes I have found myself in opposition to the dominant power in an organisation. Sometimes the challenges I have raised are not in the best interests of those in power; furthermore, I have not always had the positional power to make change happen. However, over my life journey I have developed high-level coaching skills which I have used to facilitate inquiry and critical reflection. I have utilised non-combative yet persistent dialogue (Fillery-Travis and Cox, 2014:453) teamed with research skills to gather data and evidence (see Figure 2.1). This has enabled me to make my contribution to professional practice and change the working lives of many employees.

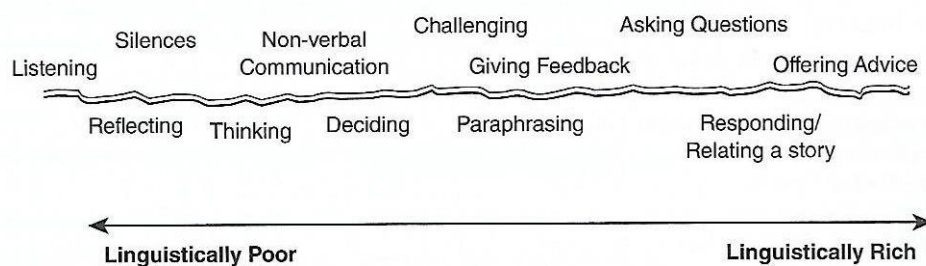


Figure 2.1 Interactions in the coaching process (Fillery-Travis and Cox, 2014:453)

## **CHAPTER 3. RESEARCH PURPOSE, AIMS AND QUESTIONS**

This chapter sets out the conceptual genre of my study, the aims of the research and the specific research questions to be addressed. My study is a democratic and collaborative inquiry, situated in the convergent contexts of the NHS and DDRB; I aim to explore the views of SAS doctors on aspects of their new contract, rather than search for an absolute truth. The purpose of this investigation was to understand why SAS doctors were dissatisfied with the new contract that had taken several years to negotiate with the NHSE. This dissatisfaction and poor morale was evidenced by the continuing poor results of the BMA Survey (BMA, 2009b).

### **3.1 An Overview of the Research**

A critical genre has emerged in the field of social sciences and applied fields, such as HRM, which is key to my study. The often assumed neutrality of inquiry has been challenged; rather, research is interpretive, fundamentally political, and involves issues of power. Furthermore, there is a school of thought that traditional social science research has silenced many marginalised and oppressed groups in society by making them the passive objects of enquiry (Denzin and Lincoln, 2005 and 2018; Marshall and Rossman, 2015:20). Accordingly, I aim to create a space where those I study can speak and be heard. I aim to show the effect of HRM practices or policy on this specific population of SAS doctors. Furthermore, I aim to make known if constraint(s) exist which affect the population under scrutiny. In achieving these aims, I will become the means of making their voices heard through the medium of the DDRB. It was not my intention to present solutions; but, through possible DDRB recommendations, to raise awareness of any issues and prompt the recommencement of a dialogue amongst the parties, in accordance with a pluralist approach to conflict resolution.

My interpretive study has three key purposes: firstly, it is exploratory, as I aim to identify any important variables; secondly, it is descriptive, as I aim to describe what is happening, especially the tacit processes and their impact; and, finally, it is emancipatory, as I aim to improve HRM practices and policy. It is accurate to state that I stumbled across the phenomenon in the course of my appointment

with the DDRB: I did not seek it; rather, it found me. This presented a personal opportunity for ongoing reflection and self-introspection to improve my practice.

Marshall and Rossman (2011:56) highlight that all genres of qualitative inquiry have a commitment to emancipation and social justice. A qualitative approach is suggested by my aim to uncover tacit aspects of organisational processes and practice outcomes. I set out to undertake a systematic inquiry to better understand the phenomenon; and by making my findings known, it may lead to a change in organisational practices and processes. I have approached this inquiry as systematically as is possible in a messy, emergent context; I collected disparate information; reflected upon its meaning; came to conclusions which I evaluated and then put forward as an interpretation of my understanding (Marshall and Rossman, 2011:55).

There were a number of possible research genres I considered but eventually discounted: amongst them were ethnography and auto-ethnography (Haynes, 2006; Daskalaki, 2012). There were elements of these approaches in my study: I was very much a part of my research process, in that I was a member of the DDRB yet also the researcher who was aiming to make sense of this experience and the SAS doctors' reality. I was the observer and the observed and, at times I felt 'inside the whale', to quote Hannabuss (2000:104). Furthermore, I became involved directly with the phenomenon but maintained an analytical perspective; through the medium of field visits to Acute Hospitals and Formal Oral Evidence sessions, I captured views, feelings and experiences of the participants (SAS doctors) and the other parties. My own experiences, thoughts and feelings informed my reflection on what I had learned during these engagements. My research approach 'provided insights about a group of people and offers... an opportunity to see and understand their world' (Boyle, 1994:183). However, ethnographic elements are also characteristic of an action research design where the subject sits in its context, at the centre of the study. I discounted framing my research within a Feminist perspective because my study involves doctors of all genders. Feminism has much in common with Critical Race Theory and its political stances but, again, I did not frame my research in this perspective as it did not include all the categories which could identify a person.

Action research is the genre which could be committed to my local context of the NHS and it created a process of democratic inquiry which blurred the distinctions between myself as researcher and the participants. Action research is often practised in organisational contexts such as the NHS; and it is used frequently by researchers who wish to question, change and improve their practice (McNiff, 2002). In taking a critical approach, my research strategy will be ideologically open, equal, empowering and democratic.

### **3.2 My Research Questions**

The following research questions are explored:

1. What aspects of the new contract are causing dissatisfaction and poor morale for the SAS doctors?
2. What problem(s) did the new contracts for SAS doctors fail to resolve, and why?

## CHAPTER 4. LITERATURE REVIEW AND THEORETICAL CONTEXT

This chapter sets my work into the context of the formal literature. Through the review of my earlier research, I have sought to develop ‘sharper and more insightful questions about the topic’ (Yin, 2014:15). The chapter starts by looking at the *what*, in terms of current literature; the remainder of this chapter considers areas which relate to the *why*. The review covers contemporary secondary data pertaining to the phenomenon; then extends to the theoretical concepts of the nature of evidence, employee voice, power relations, discrimination, critical theory and critical advocacy-orientated research.

### 4.1 The Re-contextualisation of my Professional Practice

The nature of my professional doctorate has dictated that there are two phases to my literature review. The first occurred during my time at the Review Body on Doctors’ and Dentists’ Remuneration when I was investigating this phenomenon. The second occurred as part of the process of writing this Context Statement for my professional doctorate; this phase or *cycle* is central to my critical reflection on the events that took place, and develops it into a meta-cycle of inquiry (Coghlan and Brannick, 2014:13). This re-visitation of the literature has enabled me to add further secondary data, and reflect more deeply on my practice as well as theoretical and academic contexts. It has enabled me to contextualise the originality of my professional practice, and deepen my understanding of both my experience and findings.

Initially, I considered broad areas of the HRM literature. This increased my comprehension of the context of the topic, including: employment relations, employee relations, discrimination, equality, employee voice, human capital, HRM practices, knowledge workers, organisational and social justice, pay and reward. By reading and reflecting, I am at a position where I argue that inequality and power is at the centre of this complex and interdependent phenomenon. My research context is pay in the field of HRM, but the key issues are discrimination and hegemony; where powerful interest groups may have made historical decisions that embedded power into processes. It is a *critical* issue in that my research scrutinised an extremely complex organisation (the NHS) and its myriad

processes associated with the employment, as well as career progression, of a group of doctors. It is *critical* research in that it is both necessary and essential – at the very least for the subject matter (the doctors). More widely, it is *necessary* in that the organisation's intentions were not being met nor delivered to the SAS doctors.

#### **4.2 Literature pertaining to the Review Body**

As a Member of the Review Body, I had access to data that, during each Pay Round, was not in the public arena; however, after publication of the DDRB's report, all data and evidence was released into the public domain. The Review Body could formally request research to be undertaken in areas it deemed pertinent to its decision-making, and the OME managed all requests for primary research.

The Review Body requested *evidence* from the parties each year in order to make its deliberations. The Formal Evidence was a compilation of primary and secondary data in each party's Submission of Evidence. For example, the BMA's Health Policy and Economic Research Unit undertook primary research, and would combine it with other secondary sources in its Memorandum of Evidence to the DDRB.

In this Context Statement, I have utilised much of the submitted evidence from the parties. I have found other contemporary reports, i.e. *Modernising Medical Careers: the next steps* (Department of Health, 2004); *Aspiring to Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers* (Tooke, 2008); *House of Commons Health Committee Modernising Medical Careers – 3<sup>rd</sup> Report of Session, Vol. 1* (House of Commons Health Committee, 2008); and *The Government's Response to the Health Committee Report 'Modernising Medical Careers'* (Secretary of State for Health, 2008). Reports on the medical training and careers of doctors include: *Medical training and careers – the employers' vision, Briefing 52*, (NHS Employers, 2008); *Post-certification research – a comparison of employment outcomes by speciality and certificate type* (Postgraduate Medical Education and Training Board, 2008); and *Guidance on applying for a Certificate of*

*Eligibility for Specialist Registration (CESR) under Article 14* (Postgraduate Medical Education and Training Board, 2009).

This applied literature was central to my sense-making of the context and the reality voiced by SAS doctors through their trade union, the BMA: it also explained the multiple realities of all the parties as represented by their evidence. I now move onto a discussion of the meaning of *evidence* in the formal literature.

#### **4.3 Evidence and Reality – the Competing Perspectives**

To understand the nature of *evidence*, there are three questions to consider (McNamara, 2002:22). For *whom* is the evidence intended? In what *context* is the evidence to be used? For what *purpose* is the evidence to be used? Many researchers and governments consider evidence to be empirical research; this data may be described as *research* evidence. Yet there are many alternative theoretical approaches, such as qualitative research or critical theory, which argue their approach is both reliable and valid. With the rise of the professional and knowledge-based economy (Stewart, 1998:12), there are HRM, teaching or medical profession practitioners who have the knowledge, understanding and skills to develop *experience-based intuition*. This has led to clear distinctions between research-based; research and evidence-based; evidence-based practice and evidence-informed practice, as outlined by McNamara (2002). This latter concept is enhanced through critical reflective practice (Brookfield, 1998; Cunliffe, 2016) but derives from the practitioner's experience-based intuition (Sebba, 1999). This further emphasises how critical reflection and reflexive practice may facilitate a deeper meaning and understanding for me, as both practitioner and academic, of the multiple realities of the organisational HRM practices and policies that I seek to understand (Rossman and Rallis; 2010; Cunliffe, 2016).

The literature reveals valid claims that politicians and government departments have ignored professional judgements. Two decades ago, Rolfe (1998) suggested the top-down research-based practice advocated by the Department of Health was an unhelpful model. Instead, he advocated clinical practitioner-based research with personal and experiential judgement, when applying knowledge locally to individual patients. Later, McNamara (2002:23) claimed that the



Department of Education, the Teachers' Training Agency, local education authorities and politicians were all guilty, at times, of ignoring teachers' professional judgements. Therefore, there is a history of political or government bodies ignoring professional judgements. Significantly, this same issue has occurred in the healthcare professions, which may suggest that the Department of Health appears to present a notion of evidence-based practice that favours external evidence and theory over practitioner-based knowledge (McNamara, 2002:25).

The approach that professionals take to deal with the complexity of work issues was originally considered by Schon (1991) and, subsequently, Fish (1998). Schon (1991) noted there are easy areas to make effective use of research-based theory and technique, but it is the difficult areas which are 'confusing messes incapable of technical solution... [that are] the problems of greatest human concern' (Schon, 1991:42). It is significant that in Sackett *et al.*'s (1997) 'Hierarchy of Evidence', qualitative approaches and personal communication are listed as the *lowest* forms of evidence. However, for the purpose of my inquiry, qualitative approaches are the most effective for uncovering the human experience. Fish (1998) suggests questions should be designed that are based on our observations of either our inner self or things we have witnessed. In essence, this is reflecting on experience; then testing those experiences within our own individual values bases and understanding.

Morton-Cooper (2000) argues that deregulation in the UK economy, especially health and social care, has actually led to increased state control. This is claimed to be evidenced by competency-based education, increased regulation under the cloak of quality, clinical governance and evidence-based practice. All are imposed rather than being part of a democratic discussion; other forms of inquiry are deemed not to be sufficiently evidenced. McIntosh (2010) builds on the work of Morton-Cooper to provide another useful perspective, describing his approach as *practice-based evidence*. He has a healthcare background and raises concerns about evidence-based practice. He describes the introduction of managerialism and audit into healthcare organisations; and contends that both approaches are heavily influenced by rationality and objectivism (a view supported by Delbridge and Keenoy, 2010). It is leading to a battle between organisational efficiency and

productivity, against professional values. He concludes that 'we need to re-think the nature of what constitutes evidence [and] identify what is occurring between human beings that actually makes things work' (McIntosh, 2010:22). He argues that questions are much more than diagnostic, and, like Fish (1998), he reasons they are often ontological in origin. Furthermore, he asserts that questions may seem subjective in the light of a current culture, but that they are also a personal truth or reality to those involved, and this may cause a tension.

The DDRB was obliged to follow its remit to take 'careful account of economic and other evidence' (Review Body on Doctors' and Dentists' Remuneration, 2009:iii). This is in line with the dominant practice of requiring evidence from a positivist paradigm which appears to support the current political system and culture. However, the literature shows that there is divided opinion, and that evidence-based policy and practice oversimplifies *complex* problems. Frequently, empirical research has failed to take into account the competing perspectives and multiple realities for many individuals and groups, by assuming that there is one single reality that is independent of any observer; this *single* reality is disputed (Yin, 2014:17). To conclude, empirical research often serves the purposes of those already with power; and it fails to acknowledge the reality of oppressed or disenfranchised people. If social, cultural, political or economic realities are not taken into account, societal inequalities are legitimised and will continue to affect people.

#### **4.4 Employee Voice**

I now consider the literature on *employee voice*, and examine how employees raise concerns. Employee voice is a very disparate term. It is not only about communication but is also about *influence*. These two dimensions are critical to success or failure. Much of the literature is centred at an individual or micro level and in the sphere of organisational behaviour (Godard, 2014; Pohler and Luchak, 2014). At the micro level, it describes an e-mail or a discussion; whereas, at the macro level it describes a national strike. This interest in behaviour links closely to personal development and behaviour which, in turn, is connected to the internal aspect of how we communicate. It is of note that Morrison's Voice Model (2011) omits most external environmental factors; therefore, fails to acknowledge their

importance or impact on employment relations. These omissions have the potential to lead to a very narrow perspective, which ignores relevant and influential factors at an organisational level. Morrison (2011) presumes that employment relations are unitary, but ignores the possibility of a pluralist relationship between employer and employee. Furthermore, her model does not address organisational failures, i.e. maintaining justice and protecting employee rights.

Some authors from the labour economics field link voice with trade unions and collective bargaining (Addison, 2005; Kaufman, 2015). Klaas *et al.* (2012) also acknowledge the collective voice, potential conflicts of interests and the need for dissatisfied workers to have access to justice. Wilkinson *et al.* (2014) explain employee voice is the way that workers attempt to have a say and influence organisational matters which affect their work. Kaufman (2015) supports this view and observes that a significant factor of voice is the *justice orientation*, which stems from dissatisfaction and potential conflict of interest. His Employment Relations Model (Figure 4.1) is overarched by the external environment, and includes significant external factors such as legislation, the economy and cultural-social factors (Kaufman, 2015:23). Legislation pertains to employee rights, trade union organisation and bargaining, regulation and co-determination. Furthermore, Kaufman makes a link between the external environment and the employment relationship; this emphasises the significance of the relationship between employer and employee.

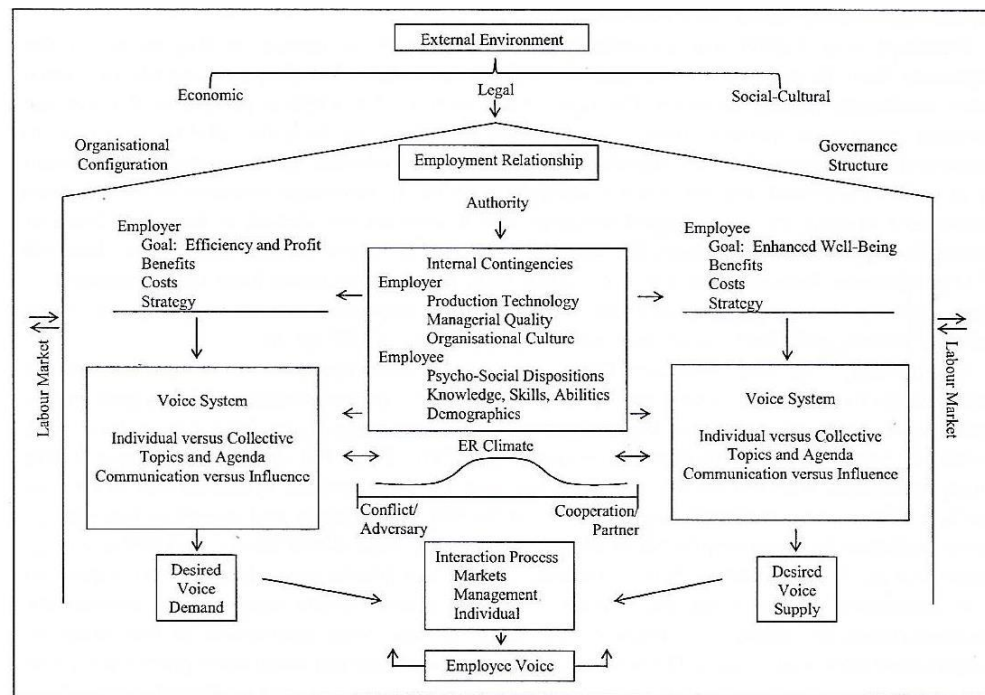


Figure 4.1 Employment Relations Model of Employee Voice Determinants (Kaufman, 2015:21)

A further aspect of justice is equity in the area of *reward*. Lawler (1986) discusses how companies delegate four critical aspects to encourage high-involvement from workers: information, knowledge, reward and power. Frenkel *et al.*'s (1999) Model of Work highlights more clearly the importance of knowledge in the Expert and Network dimensions; highly involved knowledge workers have an expectation that individual expertise and knowledge is both recognised and rewarded. This focus of this study is on HRM practices which interrelate to pay. This is illustrated in Brown's (2001:115) early framework, *A Way of Thinking about Total Reward*, which highlights the significance of learning and development, and career progression. In the guise of career development (or progression), successful learning and development may lead to two reward outcomes for an employee. The first is a tangible (or transactional) financial benefit if career progression leads to higher pay; the second is an intangible, relational reward which relates to job satisfaction, being part of a team and achieving one's potential. Morrison's model (2011) only briefly mentions reward; however, Brown concludes that 'our reward strategies [need] to adopt a more inclusive, employee and process-focused, evolutionary approach' (Brown, 2001:15). Therefore, inclusivity and employee-focus is likely to have greater significance than Morrison states.

It is significant that Ng and Feldman (2012) found, in their meta-analysis of 55 studies on the relationship between job stress and voice, the higher the job demands and stress, the less likely managers will have a voice. This negative association can clearly be applied to one of the most stressful jobs: being a doctor. It implies that this group of workers is the least likely to complain, because of the professional demands of being a doctor. Therefore, the eventual high levels of poor morale in SAS doctors could be the 'tip of iceberg', if we follow Ng and Feldman's reasoning. The formal and collective voice described by the literature is represented in my study by the doctors' trade union, the BMA.

Morrison (2011) does acknowledge the issue of *governance* and how bureaucracy and hierarchy stifle voice. The literature on Critical Human Resource Management claims that employee voices are normally excluded or, at least, not well represented, in the evaluation of management practices and power relations, i.e. minorities, women and other groups who routinely endure discrimination (Delbridge and Keenoy, 2010:804). Pope and Burnes (2013:676) claim the NHS has a 'resistance to voice and to "knowing"' and that managers prefer to ignore the issues.

#### **4.5 Power Relations**

I will now discuss the literature on power relations. The concept of power is far reaching; therefore, I will give a summarised account of power then focus on the aspects most relevant to this study. Power can be on an individual, organisational or state level. Power has been defined as behavioural (Blau, 1964; Lukes, 1974; McClelland, 1975), essentialist or economic (Foucault, 1980) and integrative (Boulding, 1989). Power in relationships occurs between individuals and institutions, which may lead to conflicts of interest when power is exercised (Bachrach and Baratz, 1979; Lukes, 1974; Lipman-Blumen, 1994).

Managers' power within organisations can be analysed and explained by several approaches: orthodox management and organisation studies (function approach); Critical Management Studies (socio-political approach); interpretive, discourse-oriented and constructivist concepts (interpretive-discursive approach) and anthropological, socio-psychological and sociological approaches (socio-cultural

approach), according to Diefenbach *et al.* (2009:413). In practice, many of these approaches are intertwined.

From an interpretive-discursive perspective, the Foucauldian explanation of power emphasises its relational characteristics, and its 'existence depends on a multiplicity of points of resistance' (Foucault, 1980:95). This 'resistance' is key to the exercise of power, but also to change and the de-construction of power relations by transforming (or re-constructing) social values and institutions. Not only does power reside in institutions such as the state, but also in social relations and practices (Kerfoot and Knights, 1994:81) which is specifically relevant for my study. In addition, power has a history, targeted in such a way as to discipline individuals and regulate groups. For example, gender has inherent power dynamics (Hartstock, 1989; Radtke and Stam, 1994), as do race and ethnicity. Power relies on a dominant discourse, so feminists will frequently resist a discourse that privileges men over women. In Foucault's (1977) view, hierarchical surveillance, normalisation procedures and 'the examination' are the most dominant instruments of power in modern society. People are constrained through external observation (by management and even each other), segregation, and judgement of populations. These aspects all apply to organisations and may produce a subjectivity that generates an internal self-discipline within employees, especially professionals such as doctors, which is utilised by organisations as self-control. Therefore, even with modern HRM practices such as leaderless teams and empowerment, indirect managerial power and control is undisturbed. This underlines the dominance of managerial power and the reality that even in modernisation programmes, such as the NHS, it is the employee who has changed terms and conditions, while managerial rights and responsibilities are left intact or are even, subtly, enhanced (Diefenbach *et al.*, 2009:427).

In the practice of employee relations, the relative balance of bargaining power between buyers and sellers of labour services is a fundamental concept (Gennard *et al.*, 2016:2). Bargaining power is shaped by the external context; therefore, any changes in government political or economic policy, labour markets or employment legislation can change the way employers and employees interact. Although some aspects of legislative change strengthened the individual power of employees (i.e. *Equality Act 2010* (2010 [online])), other changes such as *The Trade*

*Union Act 2016* (2016 [online]) place restrictions on when trade unions may take industrial action, and thereby increase the power of management when dealing with trade unions. In terms of economic policy, in 2010 the Government imposed a pay freeze and subsequent 1% cap on public sector workers who earn over £21,000: as a result, there has been little wage growth; this applies further economic restrictions on employees. Trade union membership in the UK had been in overall decline, although many unions have since reported an increase in membership during these low wage growth years.

I now examine why people enter these power relationships in the workplace. There is an 'authority relationship' from the outset between employer and employee (Gennard *et al.*, 2016:12). The relationship between the two parties is mainly unequal – the employer can replace the employee much more easily than the employee can find alternative work. The employee contracts to provide services and obey all reasonable instructions; furthermore, the employee is expected to provide effort, commitment and performance to agreed levels. In return, the employer guarantees work and payment. However, there are deeper issues that shape the relationship: autonomy, control, security, satisfaction, status and power (Gennard *et al.*, 2016:13). These intangibles have been described as the Psychological Contract (Schein, 1978; Rousseau, 1995; Guest, 2004). The relationship is not only unequal but is dynamic, rather than static, and is in a constant flux of change – socially, economically and institutionally. To conclude, the exchange of labour for reward is not straightforward or simple: the parties are not on equal terms; power relations are 'asymmetrical' (Gennard *et al.*, 2016:31).

Power inequities are used by employers to control both the labour process and employee relations; and to preserve the status quo – this can be in terms of gender, ethnicity, economic power or status. This aspect challenges the pluralist perspective that different interests can be accommodated through the process of conflict resolution (i.e. collective bargaining). As stated earlier in Chapter 2, in his *Frames of References* (Unitarist, Pluralist and Radical), Fox (1974) proposes that there is a disparity in power between the employer and employee. Alternative theoretical approaches to employment relations include Systems Theory (Dunlop, 1958); the Marxist Approach (Hyman, 1975); Labour Process Theory (Braverman, 1974); and feminist perspectives on employment relations (Wajcman, 2000).

The de-skilling of workers and the control of tasks (as allocated by management) draws upon Taylorism and is still practised today, despite the rise of professionalism and the knowledge worker in the late 1990s. Instead, the Foucauldian concept of responsible autonomy, or self-regulation, can be seen in today's knowledge workers. Knights and Willmott (1990) have three perspectives on the relationship: they conclude that it is either the outcome of a capitalist and exploitative capital-labour relationship; the outcome of a domination involving control and resistance that arises in the effort to secure autonomy (i.e. from markets and bureaucracies); or, the emancipatory potential, which is dependent on how employees view themselves and subsequently change the labour process.

It is often an assumption, and taken for granted that management is presumed to act independently and arbitrate between conflicting interests. However, the role of management (such as in the NHS) is to ensure maximum efficiency, and this aspect may well be given higher priority in decision-making, rather than other equally important issues (to employees) such as inequality, discrimination, power and privilege in the workplace (Knights and Willmott, 2012:179). Management decision-making often seeks to control the way work is organised, the pace of work, and the duration of work. HRM practices used by management upon employees can ensure the desired control over the workforce: appraisal, job planning, development plans, recruitment, career progression or team-working can be viewed as more than a neutral mechanism for improving the management of employees. They can be viewed as an exercise of power which Knights (2006:732) argues can control the workforce by 'transforming individuals into subjects that secure the sense they have of themselves, their identity and meaning through engaging in the practices'. The discourse of HRM provides a rational means of regulating the workforce and exercising power over it (Townley, 1993) but does not necessarily enhance its employee relations. Management practices involve socially embedded constructions that have developed over time (Knights and Willmott, 2017). Therefore, they are not inevitable and they can be changed, but the historic and prevailing discourse has been essentially masculine and very dominant in organisations. Professional organisations, such as the NHS, are characterised by power and status hierarchies (Currie *et al.*, 2015:794). With regard to gender, gradually women have joined the workforce and now work in traditionally male industries, as well as serving in high-level roles; ethnicity and



race have been slower to permeate into organisations. For gender, race and ethnicity, equality is an ongoing slow process. It has been argued that HRM practices and language have continued an historical discourse which merely reproduces power relations already in place, i.e. the masculine discourse (Townley, 1993). This gives HRM a critical aspect and is no more than rhetoric, according to Legge (1995; 2005).

In contrast, the Critical Management Studies literature challenges inequity, oppression and the mainly instrumental and unitarist approach of management (Alvesson and Wilmott, 1996; Fournier and Grey, 2000). In 2003, Critical Human Resources emerged to challenge the management-privileged discourses and issues of social justice in the workplace, specifically around HRM and HRD (Bierema and Cseh, 2003; Fenwick, 2005; Brookfield, 2014). Workplace reform on denaturalising organisational and managerial power is still work in progress; while the managerial perspective, in hand with mainstream HRM, continues to claim a widespread and misleading view of how organisations function and are governed (Delbridge and Keenoy, 2010:802). The employment relationship is argued by critics to be in the background, rather than at the heart of HRM, leading to weakened bargaining positions for employees (Knights and Wilmott, 2000; Boselie *et al.*, 2009; Keenoy, 2009).

#### **4.6 Discrimination Legislation**

Employment law should regulate, support and restrain both the power of management and the power of organised labour (Khan-Freund, 1983). The function of legislation is to be restrictive, auxiliary and regulatory. The latter is of greatest interest as legislation regulates management's behaviour towards its employees (and trade unions towards their members), i.e. restricts or manages the power relations. I now consider the literature specifically around discrimination legislation.

Central to the concept of discrimination are *protected characteristics*, as defined under sections 5-12 of Part 2 of the *Equality Act 2010* (CIPD, 2015 [online]).

Protected characteristics include gender, marriage and civil partnership, pregnancy and maternity, sexual orientation, gender reassignment, race, religion

or belief, disability and age. Direct discrimination involves treating people in different ways and, therefore, a person with a protected characteristic(s) is treated less favourably than a person without that characteristic(s).

Indirect discrimination is a more difficult phenomenon to comprehend, as the behaviour appears to be neutral or the same for everyone. To be considered indirect discrimination, it has to have a disproportionate adverse effect on people with a protected characteristic (*Equality Act 2010*, 2010 [online]). Unless an employer can justify the discrimination and show it to be a 'proportionate means of achieving a legitimate aim', any employee would win a substantial indirect discrimination claim at a tribunal. There is no upper limit on the award for claims of discrimination, unlike awards made for other contractual matters such as unfair dismissal (the current upper limit as at 6 April 2018 is £83,628).

Many well-governed organisations understand direct discrimination and work diligently to avoid such impact. However, indirect discrimination is very subtle and, therefore, much more difficult to understand and identify. It is concerned with 'the application of apparently neutral rules and practices which serve *in practice* to disadvantage groups of people defined by reference to a protected characteristic' (Collins *et al.*, 2012:331). Sometimes organisations do not understand the unintended consequences of processes, policies and procedures that they put in place; at other times, dominant powers conspire to maintain the status quo, disguised as taken for granted assumptions. Well-considered policies and processes must be inclusive to all workers; for example, the DoH (2004:9) advised 'all training arrangements must comply with equal opportunities and human rights legislation and will positively promote diversity and flexibility'. However, it is the implementation of practices, which is more likely to cause inequity and exclusivity. In turn, this causes a disadvantage to the affected employees and most notably, to employee morale and motivation.

There is a body of research which highlights that the NHS has consistently failed to comply with good practice on racial equality (Esmail and Carnall, 1997; Esmail *et al.*, 2003; Esmail, 2004). Research shows that while I was investigating the issue of the SAS doctors, a range of 'institutional barriers [were] blocking the career progression of Black and minority ethnic staff' (Kaira *et al.*, 2009:115).

For women from a BME background, this is further exacerbated. It is of note that the *Equality Act 2010* (2010 [online]) and *Public Sector Equality Duty (The Equality Duty) 2011* (Equality and Human Rights Commission, 2018 [online]) did not exist when this study began, but were introduced subsequently. The legislation now requires public bodies to conduct 'an equality impact assessment (EIA) to ensure... policies, and the way they carry out their functions, do what they are intended to do and for everybody' (Perkins and White, 2011:146).

In these previous sections, I have considered evidence, employee voice, power relations and discrimination legislation. The review highlights the theme of power, the competing perspectives and the existence of multiple realities. I now consider *critical theories* and *power*, and how these theories explain why a dominant discourse may exert influence over other interpretations and perspectives.

#### **4.7 Critical Management Perspectives**

In this section, I examine critical management perspectives relevant to this study.

The generally agreed assumption about critical research is that it is not only a lens to view the world as it is, but to highlight what needs to be changed (Tyson, 2006:3). Its early roots came from the school of Marxism, which was then developed by scholars known as the Frankfurt School. It expanded, and now includes a myriad of perspectives on inequity. These include but are not limited to: Queer Theory, Race Theory, Feminism and Post-Colonialism (Hill, 2014; Denzin and Giardina, 2016; Rumens, 2016; Institute of Race Relations, 2017 [online]). The principle of the critical approach is to unpick the assumptions that are taken for granted. I am examining if inequity exists within the current HRM practices and processes which regulate the SAS doctors; these may relate to how the influence of power is felt, i.e. the silencing of employee voice, exclusion, poor career progression or discrimination.

Critical theory aims to promote self-reflexive explorations of the experiences we have and how we make sense of the world around us. It sets out to question the legitimacy of what is accepted common sense, thereby exploring our fundamental

beliefs, questioning structures and challenging suppositions. Critical theorists have developed a great complexity of ideas which fits well into the field of social sciences. Hegemonic power has been the dominant culture in western and developed countries and is associated with white, male and Caucasian dominated cultures. A dominant culture will ensure that the status quo seems natural and unavoidable, but this appearance may mask inequity, injustice or even exploitation (Tyson, 2006; Delbridge and Keenoy, 2010).

There is a body of literature on the NHS that criticises the management of the organisation; it is aimed at negative behaviours such as bullying, corruption and poor decision making. Pope and Burnes' (2013) theory of organisational dysfunction in the NHS utilise the concepts of organisational silence, normalised organisational corruption and protection of image. Although corruption seems to be moving away from this the centrality of this study, Pinto *et al.* (2008) describe two types of corruption: the first is for personal benefit; but the second is more relevant. It is a type of corruption where a group acts in a corrupt manner for the *organisation's* benefit, so that 'organizational elites, or top management team – undertake, directly or through their subordinates, collective and coordinated corrupt actions that primarily benefit the *organisation*' (Pinto *et al.*, 2008:689). Morrison and Rothman (2009) note the power imbalances in organisational roles which they believe lead to employee silence (as opposed to voice). Mandelstam (2011:232) describes the NHS as a command and control structure; Pope and Burnes (2013:691) note a strong resistance to [employee] voice and to knowing, whilst Drew (2014:177) talks of elitism and management cronyism. Francis (2015:8) identifies a culture within parts of the NHS where staff are deterred from raising serious concerns as it could impact them individually, or their career progression. Pope (2017:577) describes the NHS as 'systematically and institutionally deaf' and exhibits a 'resistance to knowing'.

This body of critical literature highlights that although staff know and see issues, raising a matter is much more difficult because of the hierarchical authority of management and fear of repercussions. This should imply that collective mechanisms, such as trade unions, would be a medium to raise concerns. However, sometimes local trade union representatives are viewed by staff as having a 'cosy relationship' with management (Pope, 2017:588).

HRM is also criticised as lacking neutrality and is viewed as a 'management tool' (Pope, 2017:587-8). An earlier study into the response of HR professionals into negative behaviour revealed that HR 'favoured management with considerable negative implications for employees, and currently, the employee voice appears denied' (Harrington *et al.*, 2012:405).

Earlier studies on power have criticised unilateral management power in organisations: Clegg *et al.* (2006) wrote of power being the heart of an organisation and that it is a 'heart of darkness' (2006:12). The King's Fund (2014:6) noted different perceptions of reality within the NHS: 'While 84 per cent of [NHS] executive directors felt their organisation was characterised by openness, honesty and challenge, only 37 per cent of doctors... felt the same'. Pope's (2017) study utilised two themes relevant to my research: hierarchical/top-down/power and HR/other roles. She noted that whilst senior management and some groups have a lot of power, 'others feel powerless and lack autonomy' (Pope, 2017:587).

This view that HRM naturally assumes a managerial perspective had been noted in other studies (Delbridge and Keenoy, 2010; Harrington *et al.* 2012). According to neo-liberal thinking, there has been a wholesale shift to replace a pluralist framing of the employment relationship, with a unitarist framing which assumes common interests of the parties (employer and employees). This has marginalised external players, such as trade unions, and even the state; placing the internal parties in a relationship of 'structured antagonism' (Delbridge and Keenoy, 2010:802). This antagonism consists of the organisation's needs to reduce labour costs, whilst employees seeks to maximize their reward, either financially or to reduce their work effort. This results in a conflict of interest, and places the employment relationship as a secondary element, rather than at the heart of managerial practice and HRM. Furthermore, the impact on managerial practice is not a primary concern (Boselie *et al.*, 2009; Keenoy, 2009). This adoption of managerial definitions of reality and language has led to a rather one-sided view of how organisations functioned and are governed, described by Delbridge and Keenoy (2009:803) as 'construct[ed] managerialist conceptions of social reality'. It is argued that these social constructions exclude employee voice, lead to organisational silence and institutionalise power inequality (Morrison and

Rothman, 2009). This has led to many instances where what is good for business is not necessarily good for employees; and 'best practice' or 'benchmarking' of HRM processes has led to unintended consequences in the longer term. Whilst CEOs are focussing on the share price of an organisation, employee output is achieved through the inputs of authoritarian managerial practices; weakened employee rights (for example, the gig economy – i.e. when is a worker an employee?) and weaker collective bargaining positions (Knights and Willmott, 2000). It therefore follows that any analysis of HRM practices should involve the construct of the employment relationship; the inherent power relationships within the NHS between management, HRM and doctors; the exclusion of employee voice; and institutional inequalities.

#### **4.8 My Reflection on the Literature**

As the researcher, my expertise in Human Resources did steer me initially towards the broad literature on HRM. The context of this research and the phenomenon sit within the *context* of pay and reward, which are HRM practices. The Total Reward framework (Brown, 2001) illustrates the plethora of financial and non-financial benefits that organisations may utilise to engage their workers. Organisations should be equitable in their access and distribution of rewards to avoid, at least, de-motivation and, at worse, discrimination against any worker(s).

My critique expanded into the fields of employment relations and employee voice which have a relationship with HRM. The subjects of justice, power, organisational silence and dominant discourses subsequently emerged from these areas; they have great significance for my study. This reflects the reality of the employment relationship and the dominant power of the employer, which I know from professional experience. Kaufman's (2015) explanation of the justice orientation explains the origin of dissatisfaction in workers and potential conflicts of interest, if the employer's power is utilised in an inequitable way.

Furthermore, individual grievance systems are often insufficient when there is an organisational wide issue, e.g. the abusive and bullying culture claimed about Sports Direct (BBC, 2017 [online]). When there is an organisation-wide failure to ensure internal justice to workers, even if an individual case has merit, then an organisation's culture and hierarchy will continue to sabotage any further

individual effort to achieve justice. Ultimately, this may lead to employees seeking redress externally, i.e. via the Employment Tribunal legal system.

My reading then followed the discourse on power in the employment relationship, to the nature of power relations, and the nature of *evidence*. There is a quandary between types of evidence, especially evidence that challenges the dominant view. McNamara (2002) argues that there is a culture in government bodies which ignores some categories of evidence, whether clinical or employment related, in favour of more traditional, empirical evidence. This may be a reason why the formal evidence submitted by the BMA on behalf of SAS doctors in 2007/8, did not result in any early remedial action. Furthermore, I agree with McNamara (2002) that traditional research sometimes has fallen short on the *change and improve* aspects: the report on career routes published by the Postgraduate Medical Education and Training Board (PMETB) (2008) contained the outcomes data which explicitly highlighted the CESR route was considerably less effective for SAS doctors compared to other doctors. Furthermore, the study highlighted 'the exploration of specific themes in more detail, such as gender, age and ethnicity' (Postgraduate Medical Education and Training Board (PMETB), 2008:59) for future research. Data on age, ethnicity and gender of the respondents, was presented in the report (PMETB, 2008:18 and 21) but no significance was attached to these characteristics, or understanding shown beyond that. I could not find evidence of action taken, or consideration that this route may disadvantage the SAS doctors' career prospects.

In summary, as I read and reflected, the intellectual and central issue in the research revealed itself to be about power relations and inequity in the employment relationship. It is significant that my study which is set in the field of HRM and, in particular, the context of pay and reward, finds that it is intersecting with areas such as equality, gender, race, ethnicity, power relations, employee relations and employee voice. Managerial power in organisations such as the NHS can create a dominant reality which tends to be employer-centric and where 'reality is redefined and reframed (Pope, 2017:593); other realities, as communicated by the employee voice are, at best, minimised; presented as neutral; or, at worst, suppressed or even dismissed. Therefore, it is important for me to be neutral and even have 'antipathy to managerialist accounts of

management and HRM' (Delbridge and Keenoy, 2010: 808) because 'generalised evidence suggests the NHS is systemically and institutionally deaf' (Pope, 2017:577). Furthermore, there are surveillance constraints on people (Foucault, 1977). For example, in the NHS, external observation is made by management through its HRM practices; through GMC and clinical professional standards; through segregation in terms of career progression (or *lack* of career progression); and the judgement of populations (i.e. is a doctor worthy to join the Specialist Register which ultimately could lead to the post of consultant?).

Therefore, my investigation may reside in the field of critical management studies. In contemporary organisations, employees are expected to accept organisational values without question, and must not question managerial interest and interpretations of how efficiency, cost-effectiveness and performance should be met (Fournier and Grey, 2000:17). Scholars have criticised HRM by utilising perspectives embraced by Critical Management Studies (Legge, 1995 and 2005; Townley, 1993, 1994 and 2004). Other scholarly discourses examine the ethics of HRM; described by Bolton and Houlihan (2007) as to the whereabouts of 'human' in HRM and its practices. The literature appears to lack 'a meaningful consideration of social power, differential interests, cultural variation and potential value conflict in the HRM literature' (Delbridge and Keenoy, 2010:807).

Delbridge and Keenoy (2010) argue that Critical HRM should be concerned with contextualising the practices of HRM within the socio-economic order of capitalism; and examining the institutions which are involved with devising employment regulation (e.g., law, collective bargaining and trade unions). The literature infers there are too many assumptions which are biased towards managerialism; Pope (2017) supports this view. Furthermore, the marginalised and excluded could be better represented in HRM theory and practice. Finally, research should be more clearly located in the 'sociological, socio-psychological, economic, political and ethical aspects' (Delbridge and Keenoy, 2010:808) as these are the realities in which HRM is located.

Boxall *et al.* (2007:4) argue that in order to analyse HRM, it is necessary to 'identify and explain what happens in practice'. This helps to build theory and gather empirical data which sets out how management *actually* behaves, i.e.



Legge's reality, rather than rhetoric (1995 and 2005). Paauwe *et al.* (2009) posit that HR research should be both critical and relevant; this may be accomplished through a process of reflexive engagement which can offer alternative descriptions, voices and interpretations that acknowledge the pluralist perspective outlined earlier. Therefore, I have not taken the assumption that the managerial perspective is the starting point for my analysis; rather, I have set out to offer an objective account of the social reality encountered by employees in my study. It aims to explore and describe 'the reality of daily lived experience of HR policy and practice' (Delbridge and Keenoy, 2010:813).

I conclude the *focus* of my study is to discover what is happening in practice. I present the case from the participants' competing perspectives around this issue: what aspect(s) of the new contract is contributing to poor morale amongst the SAS doctors; what problem(s) did the new contract fail to resolve, and why? Once known, my *role* in this study is to influence policies and practices that perpetuate marginalisation and exclusion, by using Shield's (2012) advocacy approach to research. This proactivity suggests that I am different from the traditional researcher, who *knows* and is passive, but typical of the practitioner-researcher, who is pro-active and *does* (McIntosh, 2010). It is not enough for me to *know*; I both *feel* and *believe* it is my role to present the participants' perspectives and bring change and improvement to the daily lives of these employees. I am not an employee of the NHS and my role on the DDRB is independent; consequently, I am not affected by organisational silence, and I aim to reflect the competing perspectives and multiple realities so that all voices are heard equally.

## CHAPTER 5. REFLECTIONS ON MY METHODOLOGY

This chapter discusses my research aims, research philosophy, strategy, methodology, ethics, research design, method and validity of the research that I employed in my Context Statement. In retrospect, my strategy is action research; my method is a case study. The nature of this research is messy; the design is loose and emergent which is suited to a very complex phenomena (Miles and Huberman, 1994:17).

### 5.1 Aims of the Research

As explained in Chapter 3, and in light of the preliminary feedback from the SAS doctors, my aims were: to explore what aspects of the new contract are causing dissatisfaction and poor morale for the SAS doctors; and what problem(s) did the new contracts for SAS doctors fail to resolve? It was not my intention to present solutions to the parties but, as Gray suggests:

‘reveal the different truths and realities (constructions) held legitimately by different groups and individuals... to bring people with divergent views and perceptions together so that they can collectively formulate a joint construction’ (Gray, 2014:333).

By making these issues *known*, they could be placed on the formal agenda of the DDRB which, as an independent body, would make its recommendations to the parties – the BMA, DoH and NHSE. If an issue is not known, or one of the parties has insufficient evidence to make it known, it is unlikely to reach the radar screen of evidence-based bodies, such as the DDRB. This can be explained by the phrase *we do not know what we do not know*. It is a particular challenge for a body only to make recommendations on evidence given to it by the parties involved, especially if there are multiple realities, competing perspectives and dominant powers.

### 5.2 My Personal and Professional Values

In Chapter 2, I have given an account of my background, and how that has influenced my personal and professional values. However, further reading for this chapter has deepened my understanding of the importance of my values in

relation to my retrospective strategy: action research (McNiff, 2002). It clarifies that not only have I been driven by my personal values to ascertain the competing perspectives in this matter, but also that this is a fundamental part of my research philosophy and epistemology. Furthermore, at an unconscious and conscious level, I took responsibility and worked towards improving an unsatisfactory situation for the SAS doctors. This unconscious aspect originates from my beliefs and values.

### **5.3 My Research Philosophy and Assumptions**

In this section, I set out the assumptions that I have used in my role as researcher.

Firstly, I considered my epistemological position. Epistemology is the name given to the study of 'what we know and how we come to know it' (McNiff, 2002:17).

My knowing (or knowledge) is what I do and who I am; as a professional practitioner and as a human being. My professional doctorate is a reflection of what I know, how I became aware of my knowledge, and how I put it to good use in line with my values.

I also considered my relationship as the researcher to that being researched; I viewed the context of the research as socially constructed. I took a postmodernist approach; as the simplicity of an empirical, rational explanation did not fit with the complexity of the phenomenon under investigation. My part in this research has been a central element; rather than the positivist approach of independence, I have actually been in *the thick of it*, both as a practitioner-researcher and as a Member of the DDRB. Furthermore, I was part of the cycle of improvement and change, which is indicative of *action research* (Lewin, 1946) and, in turn, aligns with the advocacy approach which I outline later in this chapter. The purpose of critical research is not only to highlight inequity but also to 'advocate meaningful change' (Shield, 2012:3). For me, there was a need for justice and equity; I accepted and took on that role and, therefore, it is important that I explain my ideological position, and acknowledge my intent and bias.

The meaning of the phenomenon in this study depended initially upon my lens and interpretation (Goertz, 2006) to produce my particular perspective. It is

significant that the findings are dependent on me; I am the original observer who describes the actions of others. Furthermore, it mattered to me that the differing views of the parties did not *make sense*; it was important to me that I should make sense of it. I reflected that, from a pluralist perspective of employment relations, it would be appropriate for the parties to have different competing views that circulate around one issue. However, to progress, the parties needed to appreciate their different perspectives, i.e. 'multiple realities [with] multiple meanings' (Yin, 2014:17). In my research, there are multiple meanings that captured the various perspectives of different participants on the key issue; these are significant to my study. Furthermore, I was unwilling to accept the single, constructed reality of managerial prerogative and, therefore, aimed to use an interpretive approach which took into account competing perspectives.

The question of my *identity* was significant in this study. Elden and Levin (1991) explain the importance of identity in their work on Participative Action Research and how it links to aims. They explain the difference between an *insider* and an *outsider*; insiders are employees or those who experience the organisation's workplace directly and want to solve practical problems in the organisation; whilst the outsider is the researcher or external expert who should be able to: 'contribute[s] to the accumulation of knowledge above and beyond a local, "context-bound" situation' (Elden and Levin, 1991:133). Because of my DDRB role together with my background in healthcare, I could be described as a partial *insider*. However, I was also an *outsider* in that I was an external, expert practitioner as well as the researcher for the study (Elden and Levin, 1991:132). This dual perspective (insider/outsider) was a challenging part of my research process. I was aware of its potential for conflict, as it was necessary for me and my fellow Members to be objective and neutral towards all the parties involved. However, there was already conflict between the parties themselves because they saw the issues from different perspectives and were in disagreement; there were multiple realities, but no single or shared reality. When I was assigned the lead role for the SAS Groups in 2008, I felt this further enhanced my legitimacy to enquire more deeply into these issues, as it was appropriate and relevant to my role.

Finally, there was my professional relationship to the phenomenon. My professional intuition (based on my experience, knowledge, skills and values as an HRM practitioner) enabled me to notice that something was *not right*. Experience-based intuition is much used in other professions, for example, teaching. For me, intuition has played a large role in my HRM career: it is also a part of my self-reflection; it draws upon knowledge which may sit in my sub-consciousness rather than consciousness; it enables me to make linkages between seemingly disparate facts. My MBTI Type Indicator profile indicates that I am highly intuitive; I seek to utilise it, especially when there is scant empirical evidence available.

With regard to bias, it is likely that there will have been some subjectivity on my part that played a legitimate role in the emergence of the final data. For example, it could be said I was subjective because I had the Lead Role for SAS Doctors on the DDRB; my HR background could make me more aware of discrimination or unfairness in the workplace; my own sense of fairness (and values) makes me want to do all I can to ensure fairness in HRM practices and policies. Therefore, I acknowledge that as the data emerged, I had a personal perception of an unfair situation for this group of doctors and felt compassion for their situation.

In terms of my relationship to the research, it is akin to that of a *practitioner-researcher*, in that I was undertaking an investigative enquiry within an organisation (Anderson, 2004:23-24). Anderson acknowledges there are difficulties in this type of relationship and, as a high-status Member of the DDRB, the subjects of the research could find it difficult to express themselves freely to me, especially if being critical of the organisation and its processes might not be encouraged, or even be discouraged. Yet it also had its advantages: being an *insider* gave me access to knowledge and experience that an external researcher may find difficult to achieve; as an experienced Human Resources practitioner and DDRB Member, any proposals made would have more authority. Lastly, as a qualified and professional practitioner (Fellow of the CIPD), I had a clear understanding of indirect discrimination, and had the legal expertise to identify it. Indirect discrimination is a particularly challenging concept for many, especially from a non-HRM background.

## 5.4 Action Research Strategy

Some researchers have a very clear and linear journey; this is rarely the case in action research, so the nature of my study was one of evolution. Earlier, I alluded to my research strategy being a journey of discovery through a process of questioning and reflection. I did not always know where I was going: I took the position that if I asked enough questions, it would increase my understanding of an extremely complex phenomenon. *Understanding* and *answers* are two different concepts in my research. As McNiff (2002:3) reflects, 'sometimes it is impossible to find an answer, and we just do the best with what we have'. Even when I came to the position of understanding that the current system of career progression was not favourably biased towards SAS doctors, there was no answer, i.e. why? The dominant power advised that the system in use was based on the policy of *Modernising Medical Careers* (Department of Health, 2004), and would continue until there was an imperative to change.

The answer (if one was to be found) had to be in the research philosophy and its imperative to change. Who was I to demand that the system be changed if it favoured one professional group of doctors over another? The answer lay in my professional knowledge and my scholarly remit, since explaining and changing the world is part of the action research philosophy.

## 5.5 My Assumptions and Ontological Position

My ontological approach and the nature of my reality were, initially, theoretical, based on intuition, experience and reflection, on a phenomenon which I identified did not make sense. In 2008, why did I not share the same perspective as others, i.e. the DoH, the NHSE and DDRB Members, who were convinced there was no issue? By reflecting, I appreciate that indirect discrimination does not exist in some people's reality, nor how they view the world. Ontologically, for some researchers, reality is both objective and singular; but in my interpretive world, reality is subjective and multiple, as experienced by the various participants in this study. On reflection, I took a critical management perspective, which aligns to who I am and how I interpreted what happened.

I believe that my orientation is that of *interpretivist*. I have a particular interest in the concept of employee voice (Harlos, 2001; Wilkinson *et al.*, 2014; Kaufman, 2015). I view any employee feedback, such as evidenced by the SAS Doctors Survey (British Medical Association, 2009b) as having validity since, for the individual or group concerned, it is their lived reality and daily experience. My coaching and mentoring experience has taught me that listening to feedback from others is core to the coaching philosophy, as it expresses a personal interpretation of an individual's reality. The challenge for the parties, with their unitarist perspective of the employment relationship, was to accept the existence of multiple realities and competing perspectives on one issue.

As the exploratory investigation continued, through my discovery of relevant empirical evidence, others' perspectives changed. Eventually, the issues were confirmed by emergent evidence, in the form of secondary data from well-validated and independent sources. I analysed and interpreted the meaning of the data: this made a convincing argument for the parties, to both understand and accept the independent empirical evidence which add validity to my interpretive conclusions.

From an axiological perspective, I reflected on the role that my values contributed to this research. I did not consider myself to be detached from what I was researching as I was a practitioner-researcher and a change agent. This demonstrates that I was very much part of the research, i.e. I was a Member of the DDRB which was an independent body; I was the DDRB Lead Member for the SAS doctors; I have a strong belief in fairness, workplace democracy and social justice. In the past, I have *put right* situations that I deemed to be unfair; so it would be reasonable to state that I was neither detached, nor value-neutral (Elden and Levin, 1991). It seems that I have clear values which guide me; I do not want to harm others nor benefit from their disadvantage, as I feel we are all interconnected. In harming others, I would only harm myself; and conversely, in helping others, I help myself. In line with my personal values and the nature of this study, I took the approach of critical advocacy-oriented research (Shield, 2012). It requires a commitment by the researcher to advocate for those whose voices are not always heard clearly, and influence policies and practices that perpetuate marginalisation and exclusion. Furthermore, it should ensure that

people's understandings are changed: any such comprehension leads to action that is both tactical and strategic; and the researcher must engage stakeholders on an ongoing basis with the implications and findings of the critical research study (Shield, 2012). This approach links to employee voice, exclusion and re-balancing power relations.

## 5.6 Methodology

Earlier, I discussed that my strategy was action research. I examined the phenomenon extensively and utilised document analysis, interviewing and some observations for data collection. Therefore, it can be considered a single case study which focuses in-depth and in detail on a single organisation (Marshall and Rossman, 2011:267). However, it is a category of case study that Otley and Berry (1994) argue arises by chance and gives the researcher both the access and the opportunity to examine a phenomenon within a particular context. I did not start with a particular set of questions: as I undertook preliminary investigations to become familiar with the phenomenon and its context; as I followed the data, the questions emerged.

However, when I had sufficient evidence to indicate that there was objective validity in the concerns of the doctors, it was frustrating to be advised that the unjust process would continue until all the parties agreed to re-negotiate the terms of the contract. In other words, the disadvantaged party had made a poor job of negotiating the new contract and that was its problem! The response did not sit well with my values, as I believe in not taking advantage of someone's ignorance or inability. The Chair of the DDRB was instrumental in guiding me around the politics of the context. It was not enough for me to *know* the process was unfair; it had to be empirically proven. I realised that, if there were to be change, I had to find secondary data, independently generated elsewhere for other purposes; then through my interpretation, based on my practice and knowledge, I could present evidence that was acceptable to all the parties.

I did not set any time limits on the study. The data collection and analysis was conducted over a period of nearly four years and was a consequence of the emergent nature of the study. There were just a small number of meetings each



year when I was able to meet SAS doctors face to face, as these could be arranged only by the OME. This was helpful, as it provided a sense of objectivity and impartiality although the timeframe was longer as a consequence.

Throughout the study, I used critical reflection to understand, evaluate and make sense of the world around me, i.e. to *know*. Mezirow (1991) identifies three forms of reflection: content, process and premise. As the study progressed, my reflection engaged with content (the issues) and process (the strategies and procedures). However, it is likely that only through the experience of writing this Context Statement that I will critique my underlying assumptions and perspectives, and therefore, engage with *premise* reflection. Coghlan and Brannick (2014:51) outline the importance of '*discovering* (seeking understanding) and *verifying* (making a judgement about what one has discovered through insight)'; both are activities in the knowing process. To develop my critical reflection, it was insufficient for me to *know*; to have the appropriate level of intellectual awareness, I needed to know *how* I knew. Therefore, I utilised the notion of *interiority* through critical reflection, to integrate action and research.

It felt insufficient to *explain* the issue; I actually wanted to *resolve* it, as in Shield's (2012) critical advocacy-orientated research approach. Barad (2007) views reflection as bound by the past and suggests that it does not necessarily invite the researcher to make a difference. She argues that 'reflection is insufficient; intervention is the key' (Barad, 2007:50). It is clear that most positivistic approaches require the researcher to stand back and not be involved. For my study, it was the opposite as I was deeply involved with the community and their issues, which were bound up in my values around fairness and equality of opportunity. In essence, this research had social purpose; it also had the essence of a critical theory approach in that it is not enough to know the world, but one should change it for the better.

As Davies (2016:76) explains, 'a diffractive analysis seeks to locate the lines of force that are at play, along with their effects on each other'. In researching the processes and the undertones of these collective organisations, there were many intangible *lines of force* at play. Diffraction also involves a difference being made

by me, the researcher. It opened up an opportunity for ‘an onto-epistemological space’ (Davies, 2016:78) where I did not know what knowledge would emerge.

A core aspect to my research was that of *emergent listening*; this approach requires the researcher to suspend judgement based on existing knowledge; it may involve the researcher taking risks and is core to ethical practice (Davies, 2016). These principles fit well with my own epistemological approach. Despite the early views of the DDRB and the long-held view of the DoH and NHSE that there were no issues for the SAS doctors, I had a different perspective. It felt risky to seek other interpretations of the phenomenon which were contrary to the views of the powerful body of the DoH. However, I had no other option; since I felt it unethical for me to concur with a view which I concluded was unfair.

Finally, I shall discuss my rhetorical position, which could be described as *qualitative*. For example, my Context Statement is written in the personal voice and denotes less formality than a positivist approach. Retrospectively, writing this work has enabled me to come to a deeper, more critical understanding of the intuitive approach that I have taken in terms of epistemology, ontology and ethics. Through the process of writing this chapter, it has enabled me to make sense and create a deeper understanding, of the phenomenon, my practice and myself. To summarise, I believe that my knowing, doing and being have all worked together on this research enquiry in a synergistic way.

## **5.7 Method**

Overall, I was concerned with solving a problem: therefore, this investigation can be described as applied research. Engagement with the literature was followed by the collection of primary and secondary data, in order to better understand this topic and its context. The process of critical reflection further enabled me to separate what was known about the topic and, therefore, what was unknown. My research method utilised exploratory overview, field visits to hear personal narratives and to collect primary data, and documentary analysis which enabled me to collect and interpret secondary data. I also created new interpretations through the analysis of secondary data that had been generated elsewhere and for different purposes (Anderson, 2004). I used the data to induce meaning; to

build a picture of the state of the employment relationship and the aspects of the new contract that were causing the dissatisfaction and poor morale. Significantly, my method ensured that I studied the participants' meanings and interpretations of their world; since it was their interpretation as 'human actors' that was important (Burrell and Morgan, 1979:232). However, I interpreted the data and made judgements about its goodness, believability and veracity into my emerging ideas (Lee, 1999:33).

### **5.7.1 Data Collection**

My data collection consisted of multiple sources of evidence: primary and secondary data, and document analysis. This was collected between 2007 and 2011. The collection of my primary qualitative data was two-fold: firstly, I undertook visits to meet SAS doctors at their place of work (UK Acute Hospitals) to ask questions of SAS doctors, and to hear their personal narratives and oral accounts; secondly, I participated in Formal Oral Evidence sessions with the BMA, NHSE and DoH where I asked questions, made unstructured observations and heard oral accounts. I collected the data and made notes of conversations and discussions from these events in my field notes, which were at the informal end of the spectrum and handwritten in dedicated notebooks. The data was ordered chronologically, which facilitated easy retrieval for later access. Field notes are 'the researcher's notes resulting from doing fieldwork... [and] may vary in formality from jottings to formal narratives' (Yin, 2014:239). After field visits, I would reflect, review my notes and write a summarising note on the key issues and questions they raised in my interpretation of the discourses heard. They were also supplemented by typed OME notes of the meetings.

My visits to SAS doctors took place from 2007 to 2011 (see Table 5.1). These meetings were organised by the OME on behalf of the DDRB as an opportunity to discuss pay and other related remit issues with staff in the remit groups and NHS management; they were said by the OME to offer a 'reality check' for DDRB Members as it was the only opportunity to meet members of the remit group in person. Typically, two or three DDRB Members attended each meeting and were accompanied by OME staff who took notes; the key points were typed up and circulated to all DDRB Members, which was helpful if I was unable to attend a meeting. Although there were some structured questions, I had an open remit

to ask any question; the SAS doctors were able to put any points to the Members they thought relevant. By agreement, these discussions and personal narratives were not audio-recorded, because they could have singled out individuals. Anonymity was preserved, so that no individual was identified or identifiable. The OME organised the informed consent of participants. The field visits were useful to check whether the experienced reality of individual doctors correlated with the DDRB's formal evidence. It was also a helpful way to draw out individual experiences that could then be used in a generalised way to follow up areas that were not evident from the formal evidence. I asked evidence-based questions, but in a way which was linguistically rich and reflexive of the situation as typified by the coaching process (Fillery-Travis and Cox, 2014). My approach to analysis was to utilise qualitative (primary and secondary data) and quantitative (independent, published secondary data).

Table 5.1 – Meetings with SAS doctors in their workplace

Date	Acute Hospital	Attended by KE
15-5-07	Belfast Health & Social Care Trust, NI	Y
19-7-07	Hammersmith Hospital NHS Trust	Y
18-9-07	National Assembly for Wales, Cardiff	Y
2008	Nottingham University Hospitals NHS Trust, Nottingham	N (I was on holiday)
2008	Guy's and St Thomas' NHS Foundation Trust, London	N (only 20 SAS doctors employed by this hospital)
30-7-09	NHS Coventry, Medical School, University of Warwick	Y
2010	Darlington	Cancelled by Trust
3-9-10	Birmingham NHS Trust	Y
1-9-11	Royal Gwent Hospital, Newport	Y
17-10-11	Kings College Hospital, London	Y

My second source of primary data was at the annual DDRB Formal Oral Evidence sessions when the Review Body Members met separately with the BMA and its SAS doctors' representatives, NHS Employers and the Department of Health. The format was semi-structured, with some prepared questions, but it was open to follow interesting lines of inquiry. In this session, all DDRB Members were present; each Member questioned the attendees and discussed the Formal Evidence submitted to the DDRB for that year. As the Lead Member on SAS doctors, I always led the questions on my remit group. It was a useful opportunity to hear the language and the discourses from each of the parties. My data

collection took the form of questioning and the taking of field notes. The OME also made formal minutes of the sessions.

Table 5.2 – Formal Oral Evidence Sessions with the Parties

Date	Representative	Attended by KE
03-12-07	BMA (am) NHS Employers (pm)	Y
17-12-07	Minister for Health/DoH	Y
01-12-08	BMA (am) NHS Employers (pm)	Y
15-12-08	Minister for Health/DoH	Y
30-11-09	BMA (am) NHS Employers (pm)	Y
14-12-09	Minister for Health/DoH	Y
29-11-10	BMA (am) NHS Employers (pm)	Y
06-12-10	Minister for Health/DoH	Y

There were no Formal Oral Evidence sessions held in 2011 or 2012 (for Pay Rounds 2011/12 and 2012/13), as the Government had imposed a pay freeze on NHS employees who earned over £21,000. The Treasury had written to all the Pay Review Bodies stating that there was no requirement to make any recommendations for the remit groups.

### 5.7.2 Examples of My Questions

The questions evolved and developed over the duration of my study. Initially, they focussed on the new contractual agreement and whether it would be accepted; later, they were concerned with the implementation of the new terms and conditions, and the perspective of the doctors on these changes. Below are examples for SAS doctors on Acute Hospital visits:

- a) Have all those doctors intending to accept the New Contract, been finalised for this hospital?
- b) What is the split between those remaining on the Old/New Contract in this hospital?
- c) Are there any issues for those staying on the Old Contract relating to pay or career progression?
- d) Are there any other issues you wish to raise? *[These questions were specifically asked by me at the visit to Royal Gwent Hospital, Newport on 01-09-11].*

Below are examples of questions raised in the Formal Oral Evidence sessions to the Secretary of State for Health:

- a) What progress has been made with the contractual negotiations for SAS doctors?
- b) Why has this taken so long to go through the Public Sector Pay Committee and the Treasury?
- c) What are your thoughts on the view that this group [of doctors] has been treated unfairly?
- d) We might expect morale and motivation of this group to be very low; why should they not be treated as a special case in this round? *[I addressed these actual questions to the Minister on 17-12-07].*

Below are examples of questions raised in the Formal Evidence sessions to the NHS Employers:

- a) Please update us on the progress of the implementation of the new contract for SAS doctors.
- b) What percentage of SAS doctors are likely to move to the New Contract?
- c) Why are some SAS doctors choosing to remain on the Old Contract?
- d) Assimilation arrangements in Scotland seem to be better than in England – would you like to comment? *[I addressed these actual questions to the NHS Employer representatives on 01-12-08].*

The final part of my data collection was document analysis: data obtained from the annual Formal Evidence submissions of the parties; and from sourced key documents relevant to the study. A list of the main documents utilised is given in Chapter 4 and directly-referenced documents are listed in the References section. I obtained data from the annual Formal Oral Evidence submissions from all the parties via the OME (around October of each year) and the DDRB's sponsored data. I also made an extensive collection of documents about the NHS, the SAS doctors, the organisational practices and procedures, GMC processes, independent inquiries into alleged issues, reports from government committees on SAS doctors and reports from PMETB. These different sources of data were aimed at building my understanding of a very complex organisation and its

context; to corroborate the same findings from different sources when it was possible; and to understand the organisational life of a SAS doctor from multiple perspectives. To summarise, for this case study research it was essential to have a firm grasp of the issues, so that I did not miss important clues. This enabled me to interpret the information, spot contradictions, and to make an analytical judgement when additional evidence was needed (Yin, 2014:76).

Each Pay Round, I read data submitted by the parties; discussed the data and questions raised within the DDRB as a group; it was then tested orally at the Formal Oral Evidence sessions with the parties – a form of sense-making. On some documents (i.e. PMETB, 2008), I undertook an analysis which had a different perspective from the original researchers. My analysis of existing quantitative data sets was intended to present different ‘interpretations, conclusions, or knowledge additional to, or different from, those presented in the first report on the inquiry as a whole and its main results’ (Hakim, 1982:1).

### **5.7.3 Data Analysis**

In terms of my data analysis, critical reflection was a key element. I reflected on Formal Evidence submissions from the parties by writing remarks and comments on my write-up of my raw field notes. Some reflective remarks were made in situ as I jotted down my notes; they were put in parentheses to denote any difference from the data. Typical reflective remarks related to: what the person was really saying (i.e. hidden meaning); pursuing an issue further in another session; cross-reference to other data or documents; elaboration on an incident that now seems critical (Miles and Huberman, 1994). My reflective remarks improved the usefulness of my field notes, as they connected my thoughts, feelings, interpretations, reactions and insights; thereby making my analysis reflexive. This eventually led to the emergence of themes, explanations and relationships. I reflected on my handwritten notes from Formal Oral Evidence sessions, which led to thoughts and reflective notes; in turn, this led to anomalies and questions for the SAS doctor meetings. Their responses led me to more reflective thought and insights; and, therefore, questions (or clarification) for the following Pay Round when we met the parties again. In the interim, questions and requests for data were sent to the parties as directed by DDRB Members. I used these events to immerse myself in the field and, by doing so, learned about the NHS

as an organisation; its practices; and its people. This immersion, the critical incidents of the meetings, along with my reflections (thought and written) upon the data; revealed hidden yet real complexities of power and practices. My immersion in this mass of raw data evolved into an 'interpretive act' where I found meaning within in it (Marshall and Rossman, 2011:222). Eventually, this assembling of my thoughts through 'a continuous process of critical scrutiny and interpretation' (Guillemin and Gillam, 2004:275) led to my findings.

The term *critical incident* is important. To be critical, an event has to have some importance in a broader context; it does not need to be dramatic or obvious (Tripp, 1993). Through my analysis that these typical incidents have been rendered critical, where I have uncovered taken for granted meanings and interpreted key turning points. By utilising my interpretations, I changed group conversations (e.g. within the DDRB and the Formal Oral Evidence Sessions about the SAS doctors) and subsequently uncovered something that had been going on without detection or acknowledgement (Angelides, 2001). Seemingly unimportant data was given significance and meaning by my inquiry; which then led to my reflections and made the matter visible, and subject to further analysis and interpretation (Halquist and Musanti, 2010:450). My criterion for critical was when the parties disagreed or there was no collaborating data to evidence; in other words, there were tensions, disagreements and multiple realities. My study produced a significant amount of data, and one of the challenges was to select data for its usefulness and centrality to the research issue (Marshall and Rossman, 2011:219). As I was not able to audio-record any of the primary data collection, I was aware my own bias may have increased my unconscious selection of data favouring my views. The OME formal notes provided a useful alternative perspective of the SAS doctors meetings and the Formal Oral Evidence sessions.

A total of 22 DDRB meetings were held from January 2007 to December 2010. Although this was not a primary data collection, it was a helpful opportunity to discuss the multiple perspectives of what had been observed and heard; i.e. sense-making of the primary data in a group context. It was also my opportunity to present my interpretation of the meaning of this data to my DDRB colleagues, as Lead Member for the SAS doctors; I tested my understanding of my insights,



conclusions and interpretation of the data. It was a useful medium to evaluate rival explanations or interpretations.

I did seek other plausible explanations for the data: I used my 'critical friend' (the DDRB Chairman) to critique my findings (Marshall and Rossman, 2011:253); I utilised member checking to ask the parties if my interpretations were credible; and I utilised peer debriefing by discussing my interpretations and findings on an ongoing basis with the DDRB members (Marshall and Rossman, 2011:221). During my time on the DDRB, members had included academic Professors, a University Vice-Chancellor, former NHS Chief Executive Officers, a former NHS HR Director, an Actuary, Business Consultants and a former Midwife. They had vast expertise between them (Gray, 2014). The DDRB always carried an Economics Professor; many Members had been very senior managers in organisations including the NHS, but few had a specialist HRM background – even fewer specialised in employment relations. Only my predecessor (for the SAS doctors' Lead) was a Professor in employment relations; reflecting on this aspect, it is interesting that as his successor, I am also an academic who specialises in employment relations. During my appointment, I do not recall any other Member with this particular expertise and, therefore, perspective and understanding.

## **5.8 Ethics**

The chosen strategy for this study was action research which is 'grounded in principles of democracy, justice, freedom and participation' (Coghlan and Brannick, 2014:146). Hilsen (2006) reasons that ethics in action research have three aspects: human interdependency, co-generation of knowledge, and fairer power relations. This resonates with my study, which focuses on: how an organisation works together with its employees, and the potential unfairness or imbalance of power in the relationship between employer and employee. It is particularly difficult in the public sector, as the government indirectly foots the pay bill. An independent Review Body is more likely to ensure a fairer, more balanced, power relationship in the area of pay between employees and employer. At each annual Pay Round, employees are invited to participate, present evidence and engage with the DDRB. It was an important consideration that I remain aware of the *positional* power that I had as a Member of the DDRB.

The Review Body was independent and had to be neutral towards all the parties. Therefore, any perceived sympathy towards a particular group could have been indicated bias; so each recommendation made had to be based on evidence. Below, I set out my ethics approach:

*Need to negotiate access.* As a Member of the Review Body on Doctors' and Dentists' Remuneration, I had unrestricted access to data and participants. Therefore, I ensured my access was used appropriately, by making such requests through the OME and the DDRB.

*Promise confidentiality.* I signed an undertaking of confidentiality for my work on the DDRB, until the data was placed in the public domain. All evidence and findings were released and made public each year. The findings were formalised in a government report which was sent to the Prime Minister for approval; thereafter, it was formally presented to the House of Commons by the Secretary of State for Health. Thereafter, the publication was in the public domain.

*Participants' rights to withdraw.* Apart from the field visits and Formal Oral Evidence sessions where I made handwritten notes, I did not undertake any primary research activities which involved participants. The Terms of Memorandum for meetings set out the ethics of the meetings: information exchanged was confidential; no participants would be identifiable; and attendance implied informed consent. Formal minutes were made by the OME and circulated after the meeting, once the draft had been approved by the attending Members.

*Keep others informed.* The Chair of the DDRB acted as my guide and mentor, so was kept aware of my findings. Findings were shared with other Members of the DDRB. The Secretariat at the OME provided invaluable assistance with finding data and providing information.

The majority of the data used in my Context Statement came from secondary sources in the NHS or associated parties. Ethics and appropriate permissions had been obtained by the original primary researchers.

## 5.9 Validity

Validity was very important to this research: only if the parties agreed that the research findings did represent the SAS doctors' reality, would there be a change or review of the current situation. Otherwise the status quo would remain. Any data used to analyse the problem required sufficient validity and reliability if findings were to be *accepted* by the employer (NHS) and the DoH. I believe that my strategy to use independent secondary research adds significantly to the validity of my study. The diverse sources and mix of qualitative and empirical data presents irrefutable evidence.

I have utilised self-validation, i.e. critical reflection, in order to verify my assumptions. The theory of reflection is central to the research methodology. Johns (2007:3) defines reflection as 'learning through experience towards new insights or changed perceptions of self and practice'. Reflection is also the basis for McIntosh's (2010) practice-based evidence where he suggests the building blocks of reflection include: practical wisdom, reflexivity, mindfulness, commitment, contradiction, understanding, and empowerment. Furthermore: 'reflection ... is hard work. It involves confrontation of ourselves and our situations, and the problems we encounter when we do it' (McIntosh, 2010:28).

During the course of the research, I have benefited from *critical friends*. The Chair of the DDRB was my critical friend; he was supportive and offered refinements to my thinking and approach. I listened to his advice and this helped me to approach the challenge with a fresh perspective. He understood the political aspect of what my research might imply, since my findings had the potential to criticise the dominant power and status quo. He supported me to better understand and handle these external circumstances, gave me opportunities to present my evidence, and ensured I had access to resources.

My colleagues on the DDRB acted as a validation group. We held regular meetings and, as the SAS Lead, I had opportunities to present my thinking and data. Colleagues included senior academics, practitioners and healthcare specialists; their insights and critiques were invaluable. During the first two years,

Members did not concur with my early ideas but once I produced the data on indirect discrimination, there was unanimous agreement.

As I write up my Professional Doctorate, I have a Director of Studies and a Second Supervisor who supervise my academic work. They act as my *academic validators* with the aim that my work has academic rigour, contributes to practice, and adds to the existing body of knowledge.

#### **5.9.1 Internal Validity**

This study is about how I am attempting to explain how and why an event *x* led to event *y*. I have been able to observe all events directly, but I have collected evidence to help me understand, know, and interpret. This is *explanation building*.

#### **5.9.2 External Validity**

Any primary research had to be approved by the DDRB. However, I utilised the DDRB field visits to explore issues with the SAS doctors. Visits took place at an NHS hospital, and were more akin to a discussion or exchange of information. There was a pre-agreed structure for the questions, but it was semi-structured so that exploratory questions or lines of enquiry could be followed. It was a fact-finding mission where DDRB members and SAS doctors could engage. The doctors' personal accounts of their *reality* gave me invaluable insight.

### **5.10 A Personal Critical Reflection and Links to Theory**

This study occurred when I was a practitioner. Therefore, my values and beliefs as outlined in Chapter 2 are central to my approach. My methodology, epistemological stance, ontological assumptions and method explain how I conducted my research. Research theory frequently gives the impression that research is linear and orderly, but I have found my retrospective study to be unclear, complex, disordered and emergent. It was a huge task of 'sense-making' in which I followed an interpretive approach to the phenomenon.

Brookfield's (1998:197) model has been useful to this study, as I consider myself to be a reflective practitioner. The model consists of four lenses, through which

the reflective practitioner examines his or her actions: through one's own autobiography; through learners; through colleagues; and through theoretical, philosophical and research literature. Reflection is a process of interiority (Coghlan and Brannick, 2014) and indicated my approach: the utilisation of self-reflection, evaluation, and by listening to personal narratives. The process of critical reflection enabled me to construct the parties' diverse realities, work out patterns and linkages between disparate data, assemble valid evidence and create a sense of knowing from the unknown. I was very much a part of my research process, in that I was a member of the DDRB, yet also the catalyst who was aiming to make sense of this experience and the SAS doctors' reality. There was certainly an ethnographic element to this study: I became involved with the phenomenon but I still maintained an analytical perspective, gathering data from as many sources as possible. Through the annual field visit to hospitals and Formal Oral Evidence sessions, I captured views of the experiences and reality of the participants (SAS doctors). My own experiences, thoughts and feelings were an important part of my reflection. It was central to my study that my interpretive approach 'provided insights about a group of people and offers... an opportunity to see and understand their world' (Boyle, 1994:183).

Shield's (2012) critical advocacy approach was most suited to my research aims, i.e. understand and change. As it was a process of reflective inquiry, questions were an important aspect. Fish (1998) suggests questions we design are based on our observations of either our inner self or things we have witnessed. Therefore, my questions reflect my experience and observations as a DDRB Member; my questions test those experiences within my values framework, and within my understanding. I find it interesting to reflect that if questions are based on my values and are, therefore, both ontological and empirical (McIntosh, 2010); those same questions may further knowledge - not just of others - but also of myself.

When the study commenced, I did not realise the full extent of the problem. As Gray (2014) states, the nature of action research can be unstructured. There was a *keep going* approach to my research that enabled me to uncover useful insights and, through reflection, new interpretations of the data.

My learning through this process has been considerable. It is one thing to identify indirect discrimination (and even that is difficult). However, to persuade others of its existence is extremely challenging; especially those who operate at a very high and powerful level in organisations and government. Firstly, there had to be the identification of the issue (from complex sets); secondly, once identified, an evidence-based case had to be made from the inferences of the data, to explain why it was happening, and its potential impact.

It was extremely important to me that this problem should find a resolution. My research journey also has implications for professional practice in the way practitioners think about reality and the world. As the Lead DDRB Member for the SAS group, I became very close to the phenomenon under investigation. Early on, through a process of sensitivity, empathy and intuition, I formed an overall sense and personal interpretation that there were indeed grounds for the dissatisfaction – possibly intuitive, if not at all well-evidenced, in the empirical sense.

This research process ran from 2007 to 2012. As part of this reflective doctoral-level work, I have also undertaken historical analysis in a meta-cycle of the literature review, to source other relevant secondary data that may add further insight to the evidence that I found during the original research phase. It was important that I design my researched in a carefully constructed and transparent way. That was, in part, one of the reasons that to support my findings, I aimed to use secondary data from independent sources that could not be refuted. It would have been all too easy for the dominant power structures to view any primary research undertaken by me as biased or influenced by my own values and views.

Although I had an intuitive feeling that inequity existed, evidencing it was considerably more of a challenge. I know from experience that issues can be very deeply buried within organisations, especially complex organisations such as the NHS. However, as a Member of the Pay Review Body, I was able to access data. I could make enquiries and search for data from any of the parties; data that may not have been accessible, for example, to the BMA. I was assisted by members of the OME team, whose knowledge of the NHS organisation was vital.

The BMA believed there was an issue of inequity, but its own empirical data was not taken seriously by the other parties. Initially, I had to persuade fellow DDRB members. In the 2009/10 Pay Round, I was advised there was a lack of objective evidence which was factual and confirmable. I demonstrated my independent critical power because I did not give up, and took personal responsibility. I proceeded with my methodological approach of critical reflective practice (Brookfield, 1998), i.e. observation, inquiry, explanation to produce a conceptual understanding of the issue, and to find if there was data in secondary sources that would provide evidence.

Other members of the DDRB had needed to be convinced that there was a detriment to this specific group. The subtlety of indirect discrimination is a challenging concept for many people. I always felt greatly supported by the Chair of the DDRB, despite being at odds at times with the majority over this particular area in the early years. Members of the Secretariat were very helpful as we collaborated to search for secondary data. During the 2009/10 Pay Round, I proposed to the DDRB that an update on discrimination legislation could be helpful for Members. Subsequently, a briefing on discrimination and employment law was approved. In addition, the OME agreed to commission research on discrimination law and pay on behalf of all the Pay Review bodies. The briefing for DDRB members was delivered on 27 May 2010 by the Pay Auditor.

In 2009, I saw myself as a professional practitioner; today, my identity is metamorphosing as a practitioner-researcher through the process of writing this academic paper. My writing is connecting me to critical thinking and deeper understanding. In retrospect, I thought I was an HRM expert: now I know I am still that expert, but I have a deeper appreciation of why I am driven to change, improve and, at times, fight for justice.

## CHAPTER 6. CONTEXT OF MY STUDY AND FINDINGS

This chapter sets out the context of my study, its key findings and my personal contribution. The data in this study comes from primary and secondary data that I collected, and from documents I analysed, unless other authors are referenced. I tried to give meaning to the data by generating interpretations of what is happening, i.e. inferences, insights and refinements of my understanding. I evaluated the impressions and reflections captured in my field notes; made connections and came to my conclusions on significant aspects.

As detailed in Chapter 5, I collected primary data from: seven DDRB meetings in Acute Hospitals with SAS doctors between 2007-11; and four Formal Oral Evidence sessions held separately with the BMA and representative SAS doctors, NHS Employers and the Department of Health between 2007-10. I was the SAS Lead Member, and it was my role to lead the questioning regarding SAS doctors at each Formal Oral Evidence session. Discussions regarding the SAS doctors were timetabled at 22 DDRB committee meetings, to which I contributed fully. I made personal field notes at every meeting and they amount to two large journals totalling around 160 pages of notes with supporting documents. The secondary data I compiled is a mixture of research reports, surveys, government reports, healthcare reports, NHS organisational practices and processes; and statistics which relate to the NHS, the SAS doctors and the context in which they work (i.e. the GMC which regulates the profession; the PMETB which provides medical training).

With regard to my contributions with the DDRB committee meetings, I was the advocate for the SAS doctors as the Lead Member on the SAS Doctors. It was my thinking that led me to consider the problems of poor assimilation of the contract; to request data on the progress of the new contract in each country; and to challenge the NHSE and DoH on how well (or badly) the new contract was being implemented. I addressed courageous questions to Secretaries of State for Health; I persistently asked for facts and data from the DoH and NHS in England, Wales, Scotland and Northern Ireland, to test the accuracy of generalised accounts given to the DDRB.



At the same time, I communicated my ideas to the audience of the DDRB at our committee meetings and slowly promoted an understanding of the issues and complexities. I was advised not to go on a 'crusade', and asked if this inquiry was 'relevant' to pay; however, the Chair of the DDRB was very supportive and encouraged my investigations on behalf of SAS doctors. Eventually, I established a link between the characteristics of the SAS workforce (gender and race), and evidenced that the HRM practice of career progression was indirectly discriminating against these doctors. As the DDRB had a remit to take into account anti-discrimination legislation, I proposed that it should make recommendations on this matter; which it did. If it had not been for my intervention, I have no doubt that this issue would be ongoing today.

## **6.1 The Context of the NHS**

In line with government policy, the UK medical workforce has undergone major change. The major change in 2004 was the policy to restructure postgraduate medical training through the Modernising Medical Careers (MMC) framework. The BMA claimed that the MMC did not allow doctors to remain within the formal structure of generalist training. Doctors who had completed foundation training could no longer wait in generalist training if they were initially unsuccessful in obtaining a higher specialist training post; instead, they were forced into the staff grade/speciality doctor grade. The alternative was to leave the UK medical workforce. This change caused an artificial growth in the staff grade posts. Prior to MMC, doctors would undertake one year of training in the House Officer (HO) level and would then enter the Generalist Senior House Officer (SHO) grade, remaining in this formal training grade until obtaining a specialist training post as a Specialist Registrar (SpR).

In 2007, there were 32,649 applicants for 23,247 posts for speciality training; by 2008, there were approximately 33,000 applications, yet posts had decreased to only 16,000 posts (Tooke, 2007). In 2009, all of the fixed-term speciality training posts expired, therefore forcing more doctors into the speciality doctor grade. Overall, there were insufficient permanent posts in the NHS system for many doctors to complete their training.

The second change, following the introduction of the new contract for SAS doctors, was the closure of the Associate Specialist grade in 2009 (NHSE, 2009). This was further compounded by a slower growth in the number of new consultant posts.

As I wrote in Chapter 1, this era suffered from political interference and poor industrial relations (see Appendix 5). The DoH was pushing through its NHS modernisation agenda, which included doctors' contracts; therefore, it was a period of massive change. In 2007, the Right Honourable Alan Johnson MP became Secretary of State for Health, and he ushered in a period of improved communication amongst the parties. He attended and engaged in the Formal Oral Evidence Session held by the DDRB.

## 6.2 Staff and Associate Specialist Grades (SAS)

SAS doctors comprised at least 16% of the total workforce at the time, making an important contribution to the overall service delivery within the NHS. Significant numbers of trust grade doctors are employed under local terms and conditions by hospitals and Foundation Trusts, and are not included in Figure 6.1, so the true proportion of SAS grades in the NHS is much higher than reported (Review Body on Doctors' and Dentists' Remuneration Body, 2010:88).

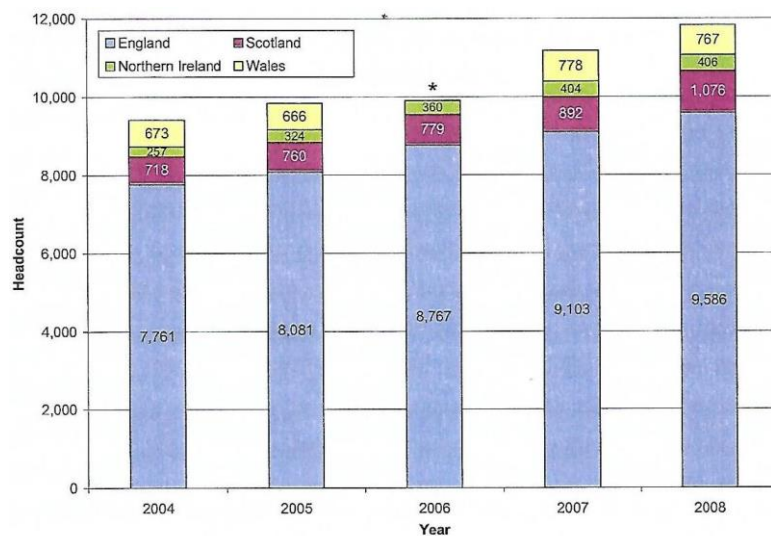


Figure 6.1 Number of Staff Grades and Associate Specialists in the Hospital and Community Health Services. 2004-2008, United Kingdom (Review Body on Doctors' and Dentists' Remuneration, 2010:88)

Between 2000 and 2007, the overall number of centrally-recorded SAS grade employees reduced from 19,175 to 18,120. Within this total, the number of Staff Grade doctors and Associate Specialists on the old contract increased significantly from 7,439 in 2000 to 11,177 in 2007. These figures corroborate the claim that doctors completing their foundation training were forced into staff grades, if they did not obtain higher specialist training post (see Figure 6.1).

Before the introduction of the new contract, the titles *Staff and Associate Specialist/Non-Consultant Career Grades* (SAS/NCCGs) were used. The parties agreed to introduce a new grade of Speciality Doctor to the new contracts, which were available to both Speciality Doctors and Associate Specialists (SAS). SAS grades were extended to include other types of doctors. I have compiled an analysis of the changes, as shown below in Table 6.1:

Table 6.1 Analysis of SAS grade job titles under New and Old Contracts

Job Title	Old Contract	New Contract
Speciality Doctor	N/A New grade	✓
Associate Specialist	✓	✓
Staff Grade	✓	
Senior Clinical Medical Officer		✓ Transfer to Speciality Doctor title
Clinical Medical Officer		✓ Transfer to Speciality Doctor title
Clinical Assistant		✓ Transfer to Speciality Doctor title
Hospital Practitioner	✓	Not eligible
Community Hospital Doctor	✓	Not eligible

This SAS doctors comprised neither junior nor senior doctors. The BMA definition described them thus:

‘they are hospital doctors who will normally have spent some time as a junior doctor but will not have formally completed training in the United Kingdom, or have not yet been judged to have acquired an equivalent level of experience in a medical speciality to be registered on the General

Medical Council's specialist register. The main job titles for these doctors are **staff grade** or **associate specialist**.

An **associate specialist** is a doctor who will have trained and gained experience in a medical speciality but has not yet attained the status of consultant. They will often work without direct supervision, but will be attached to a clinical team led by a consultant in their speciality. An associate specialist will have undertaken some specialist training and will almost certainly have attained the professional qualification to be a member or fellow of the relevant medical royal college or faculty.

**Staff or trust grades** are doctors who work in a specialist area and undertake clinics and perform procedures under the supervision of a consultant. They are not trainees but will have done some training and are likely to have a professional qualification, or part of, from the relevant medical royal college or faculty' (British Medical Association, 2016 [online]).

Figure 6.2 shows their standing in the medical hierarchy:

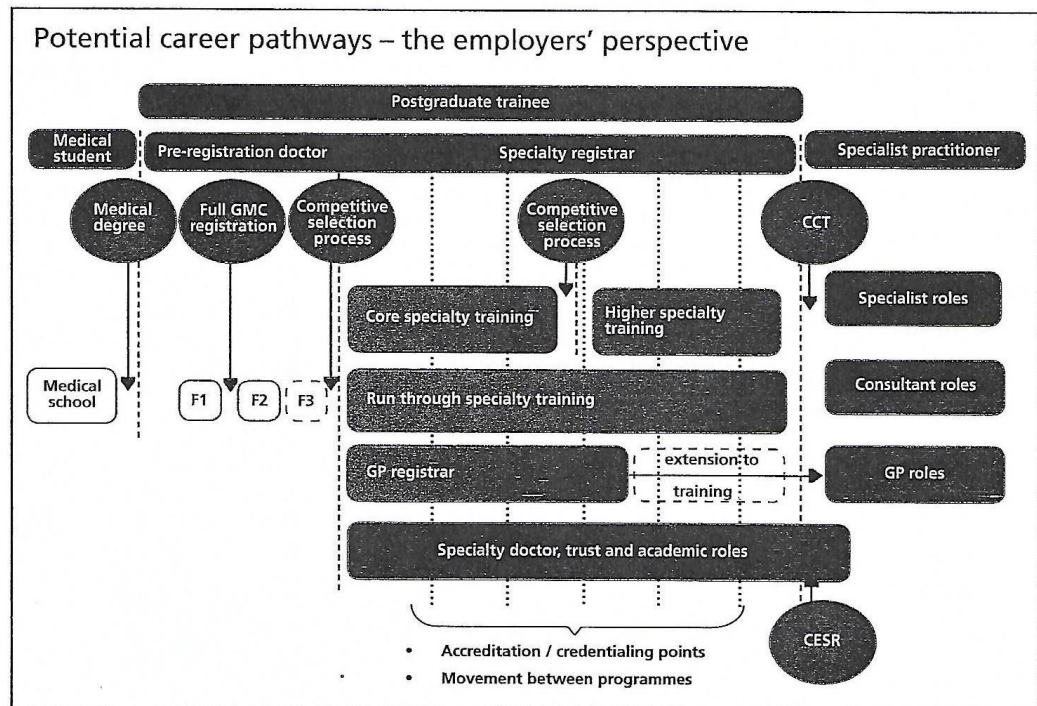


Figure 6.2 Potential career pathways - the employers' perspective (NHS Employers, 2008:6)

### 6.3 My Involvement with the SAS Doctors

All Members of the DDRB contribute to every area, but each Member would lead on a specific area. In 2006, when first appointed to the DDRB, I was allocated junior doctors as my lead area, with Wales as my cross-disciplinary area. For the 2007/8 Pay Round, I was allocated the Lead on Speciality Doctors and Associate

Specialists doctors. I had followed their particular issues with interest for the previous two years, and led on these doctors until 2012. My cross-disciplinary area changed to Motivation and Morale, which played to my strengths.

#### **6.4 Pay**

The Associate Specialist grade closed as part of the terms of the new contract and, consequently, there were genuine concerns that higher pay scales were now closed to these doctors. The new Speciality Doctor pay scales were lower, which would create a pay ceiling for those who wished to progress their medical careers. The only career route for Associate Specialist (old or new contract) would be the job of consultant. It is the impact of this change which is my main focus, and will be examined in depth later. The 2012 pay scales for both SAS grades are shown in Appendix 4.

#### **6.5 Career Pathway to the Job of Consultant**

Career progression to the job of consultant would move a doctor onto a higher pay scale (see Appendix 4) and, therefore, an increase in pay. Before being considered for a consultant's post, every doctor is required to be appropriately qualified and certified. This process is regulated by the Postgraduate Medical Education and Training Board (PMETB), which is the statutory body that regulates postgraduate medical education and training in the UK. Its role is to ensure that doctors are appropriately qualified and certified for entry on to the specialist and general practice registers, as directed by *The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* (2003 [online]).

There are two principal routes: doctors who complete a full PMETB-approved training programme are eligible to apply for a Certificate of Completion of Training (CCT): either a General Practitioner Certificate of Completion of Training (GPCCT) for general practice or a Specialist Register Certificate of Completion of Training (SRCCT) for other specialities. Doctors who have not followed a full PMETB-approved training programme may apply to have their training, qualifications and experience assessed for equivalence to a CCT level in their speciality. Doctors may apply for a Certificate confirming Eligibility for Specialist

Registration (CESR) or Certificate confirming Eligibility for GP Registration (CEGPR). The PMETB sets out this guidance in a document entitled 'Guidance on applying for a Certificate of Eligibility for Specialist Registration (CESR) under Article 14' (PMETB, 2009:7).

## **6.6 The New Contract — The Rhetoric**

NHS Employers stated that the service benefits of the new SAS doctors' contract were: supported job planning, a common working week of 40 hours, a new pay structure, and integrated career development through planned time for supporting activities. In addition to the new contracts of employment, there were enhanced terms and conditions, such as access to incremental pay scales worth between 5 and 10 per cent of base salary for Speciality Doctors and between 3 and 9 per cent for Associate Specialists. The DoH believed that the new contracts offered reform within the NHS, i.e. the strengthening of job planning, greater incentives to work evenings and weekends, and flexible service delivery. Extra reward was being given to employees in return for reform.

The BMA knew that SAS grade doctors had a strong desire for career progression and development. In order to progress to the post of consultant, SAS doctors had to obtain a Certificate of Eligibility for Specialist Registration (CESR) under the equivalence pathway of Article 14 of *The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* (PMETB, 2009:2). For any doctor, career progression to the post of consultant brought a significant increase in pay and other types of benefits, such as Clinical Excellence Awards.

It was a negotiated condition that each doctor would either need to decide to stay on the old contract, or accept the new contract. There was a timeframe in which each doctor could formally express his or her interest and eligible doctors could apply for re-grading to the new Associate Specialist contract. It was mandatory that every doctor went through the *job planning process* to ensure that he/she was on the correct point of the pay scale before transfer to the new contract.

## 6.7 The New Contract — The Reality

The reality of what actually happened with the transfer and upgrading of contracts was very different from the approach envisaged at the negotiations stage. Initially, the DoH had advised the transfers would take place from 1 April 2008. Each country (Wales, England, Scotland and Northern Ireland) was responsible for its implementation of the new arrangements. As each devolved country had slightly different arrangements, it added to the complexity of the overall transition throughout the United Kingdom. It would be fair to describe the changes as *frustrated* and lacking impetus. Bureaucracy, disorganisation and a lack of leadership from the top ensured that the new contracts took years to implement. NHS Employers cited ‘the complexity of the assimilation arrangements, insufficient support to trusts for implementation, and workforce capacity issues as being reasons for the delay’ (DDRB, 2010:89).

The restructuring of postgraduate medical training known as *Modernising Medical Careers* (Department of Health, 2004) eliminated the ability of doctors to remain in the formal training structure in generalist training whilst they waited for a higher specialist training post. This change *forced* doctors to move into the SAS grade. The BMA had argued it did not want the SAS doctors to be paid at a lower rate of remuneration than other doctors for a) obtaining the same skills and knowledge as doctors still within the formal training structure and/or b) providing the same level of service. Furthermore, the SAS grades were not to be seen as an alternative to the formal training system for all doctors (British Medical Association, 2009a). At the same time, there was an increase in specialist training posts but a decrease in the growth of new consultant posts. This further limited the opportunity for a SAS doctor to progress into a consultant post – the next step in their career pathway. Feedback to the BMA from Junior Doctors revealed that they did not view the SAS grades as an attractive career alternative, thereby further isolating those doctors already in the SAS grades.

## 6.8 My Role from 2008 onwards

As DDRB Lead Member for the SAS doctors, I led the questioning on this group at the Formal Oral Evidence sessions. In my experience, gaining the support and

championship of the senior leader is critical to success in any challenging endeavour. I remember asking questions of the Secretary of State for Health regarding the slow implementation of the new contracts for SAS doctors. Initial non-specific answers met with my firm repetition of the question – three times – until I received a definitive answer and commitment. I recall the Chair of the DDRB attempting to catch my eye, as I seized my moment to highlight the injustice for these doctors; and I, terrier-like, would not relinquish the floor until I had received acknowledgement of the issues, and commitment to change! To this day, I am pleased that I found the courage to behave so authoritatively and persistently; and in front of this specialist audience. The large venue was stuffed with senior officials from the DoH, other DDRB Members representing their elite fields of academia, economics and pay, the OME staff and, of course, the Secretary of State for Health. Something just came from within me and I found myself obliged to persist in my questioning; it was the *just* thing to do.

Formal evidence presented by the BMA had set out the continuing poor morale of the SAS doctors. I envisaged that this was likely to be a consequence of long, drawn-out negotiations for the new contract, further compounded by the lengthy implementation of the new grades and contract (over four years in total). SAS doctors had agreed to the new contract and reforms, but were disappointed with their career progression, development and training. Formal evidence convinced me increasingly that the new contract was not delivering the career progression component that had been a key element of the collective agreement to accept new contracts. Corroborating data emerged from the Formal Oral Evidence hearings, written evidence submitted by the parties, and hospital visits where I and other DDRB members met with SAS doctors. Their dissatisfaction centred around the claim that few SAS doctors were moving from their current grade to the consultant post. This affected their remuneration, since pay scales were linked to the job and grade.

SAS doctors, supported by the BMA, had complained formally but advised the DDRB that neither the NHSE nor the DoH would take this dissatisfaction seriously. Essentially, this was a stalemate between the DoH, the NHSE, and the BMA.



The DDRB took a neutral stance, suggesting the BMA was not presenting sufficient evidence to make an effective case. Although the DDRB did invite the BMA to provide more evidence, this highlighted a key issue which was discussed in the Literature Review – when is evidence worthy, and who makes that judgement? The other parties did not accept the *reality of* the SAS doctors’ perspective. They firmly believed the newly-introduced contract was able to deliver better career progression: they did not wish to consider it was failing, or to review it.

Based upon my HRM expertise, I felt that, if there was to be any change, the parties would need to accept there was a problem (even if the extent or the cause were not yet known); and work together in order to resolve it. Yet I was the only Member who was overly concerned. I knew it would be vital to ensure that the all members of the DDRB recognise the issue. I determined I had a responsibility to objectively examine the data and determine if there was any alternative explanation(s).

## **6.9 My Findings**

Each Pay Round, the OME arranged one field visit to a UK acute hospital to meet SAS doctors; one Formal Oral Evidence session was held with each party, i.e. the BMA, DoH and NHSE. This gave me occasional access to all the parties and SAS doctors. Otherwise, I relied on the formal evidence submitted by the parties and secondary data produced by my literature search and the OME.

Preliminary data from my document analysis showed that considerably fewer SAS doctors successfully obtained CESR, compared with doctors who had gone through other certification routes: CCT (SRCCT, GPCCT) or CEGPR. A study entitled *Post-certification research – a comparison of employment outcomes by specialty and certificate type* (PMETB, 2008) provided me with useful data. Through analysis of the report, I aimed to ascertain if there was any substance in the SAS doctors’ dissatisfaction with the new contract’s career progression opportunities (British Medical Association, 2009:27-28). The report had been commissioned by PMETB and conducted by ICM Healthcare on its behalf. The main aim of the survey was to explore what happens to doctors in terms of employment opportunities, after they have been issued a decision by the PMETB.

The research was conducted in two phases, then analysed using SPSS version 16; it covered all applicants who had gone through the certification process and had received a decision. For CESR/CEGPR applicants, the period covered 1 September 2005 to 30 April 2008; for CCT applicants, the period covered 31 October 2006 to 30 April 2008 (11 months less than the CESR/CEGPR group). The response rate to the survey by the total number of applications in each route during the survey period, by application route, is shown in Figure 6.3 below:

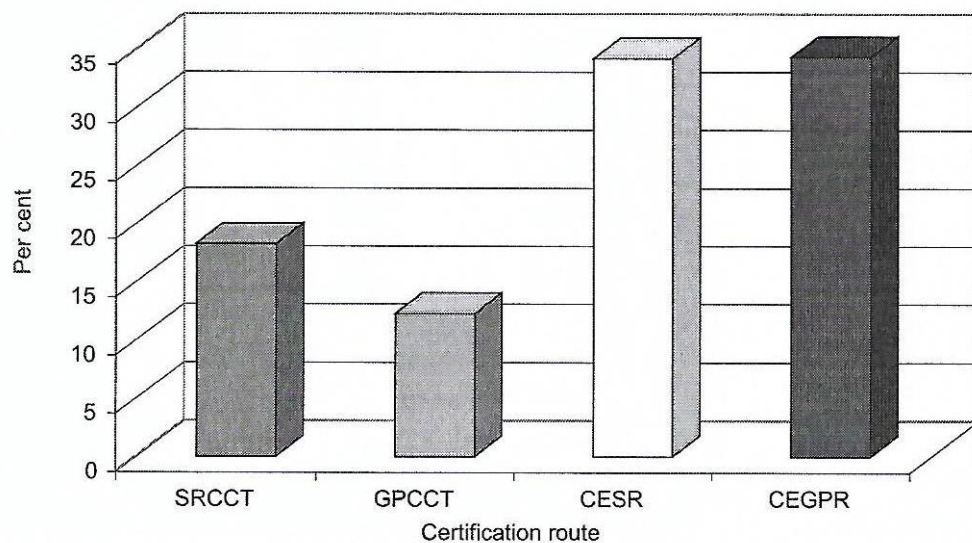


Figure 6.3 Response rate by total number of applications in each route during the survey period by application route (Postgraduate Medical Education and Training Board, 2009:17)

The report noted that the PMETB had issued certification decisions to more than 22,000 doctors: 18,184 were Certificate of Completion of Training (CCT), and 4,159 were Certificate confirming Eligibility for Specialist Registration (CESR) or Certificate confirming Eligibility for General Practitioner Registration (CEGPR). Of the latter group, 1,641 (39%) were unsuccessful. No doctor (0%) was unsuccessful in obtaining the Certificate of Completion of Training (CCT), as it is a full PMETB-approved training programme which leads to eligibility for a CCT and a successful application. The report explains that 'in practice the potential for an unsuccessful application is only possible for applicants going through the equivalence route (CESR or CEGPR)' (PMETB, 2009:7).

The primary researchers utilised the following methodology: the survey was sent via e-mail to all applicants, whether successful or not. Those who did not respond to the online survey were followed up in Phase 2 of the study by telephone; they

were asked the same questions that had been asked in the online survey. This second phase was conducted with the aim to ensure as broad and representative a sample of respondents as possible. Figure 6.4 below shows the response rates:

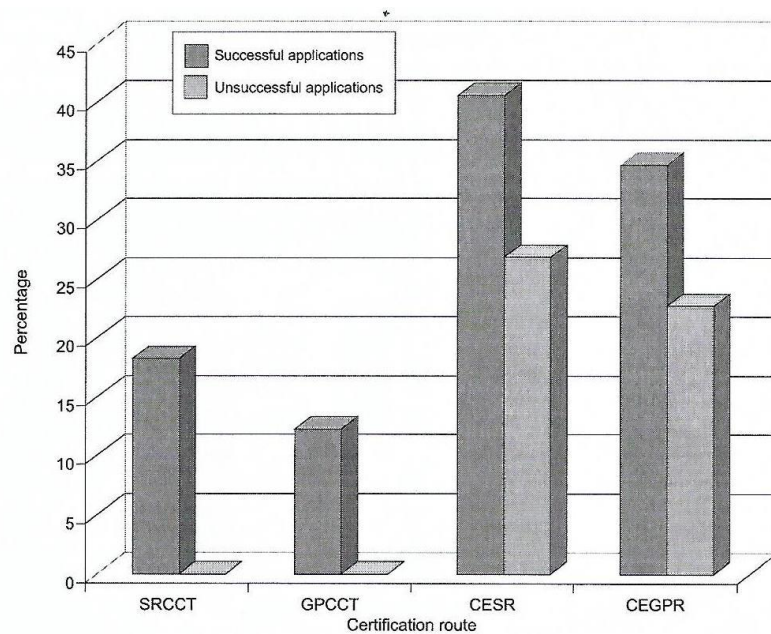


Figure 6.4 Response rates for each outcome and route based on total number of decisions issued with that outcome in each route during the survey period (Postgraduate Medical Education and Training Board, 2009:18)

Out of the four potential routes open to all doctors, the only route available to SAS doctors was the CESR route: only 66% of CESR applicants were successful. Other doctors had the options of SRCCT, GPCCT and CEGFR, as well as CESR. Furthermore, 98% of CEGPR applications were successful, and 100% of both GPCCT and SRCCT applications were successful. This data then revealed the next question for my study: if the only route available to SAS doctors is the CESR, why were so many applicants (34%) unsuccessful? The findings stated that 'in both populations the vast majority of unsuccessful applications were those through the CESR route' (PMETB, 2009:19).

During my field visits and the oral evidence sessions, I had observed the high level of diversity in the SAS doctors. Many were women; a large number of men and women were from *BME/BAME* backgrounds. A number of doctors had been recruited by the NHS from overseas, especially the Indian sub-continent.

It is significant that the PMETB report notes:

‘a greater proportion of males than females were unsuccessful (11 per cent and six per cent respectively), and a greater proportion of ‘other ethnic group’ and Black or Black British were unsuccessful (21 and 18 per cent respectively)’ (PMETB, 2009:21).

I looked further in the report for information on the profile of applicants. There was data on age (see Table 6.2 below) but it did not reveal any significant trends. There was also some analysis on gender, but only by speciality and success.

Table 6.2 Outcome of application by age: CESR and CEGPR applications (Postgraduate Medical Education and Training Board, 2009:20).

Certificate	Outcome	Age Group				
		25-34	25-34	25-34	25-34	25-34
CESR	Successful (%)	66.7	63.6	69.3	62.3	0
	(n)	6	91	174	43	0
	Unsuccessful (%)	33.3	36.4	30.7	37.7	100.0
	(n)	3	52	77	26	2
CEGPR	Successful (%)	100.0	99.2	90.0	100.0	0
	(n)	123	122	36	10	0
	Unsuccessful (%)	0	0.8	10.0	0	0
	(n)	0	1	4	0	0

Following the modernisation changes, the *only* route to progression to the post of consultant for SAS doctors was now through the CESR process. However, I noted in the PMETB report (2009) that there was a significant failure rate (34%) for SAS doctors taking this application route. Only 66% of CESR applicants were successful, whereas other applicants had very high (98%) or total (100%) success rates in the other routes that were not available to SAS doctors. When I presented the data, it was considered unfortunate but probably based on ability.

By combining my practitioner knowledge with this data, I realised there was another meaning. This is how I made the difference. If the SAS doctors’ ethnic and gender profile had been similar to other groups of doctors, there would not have been the potential for me to claim that this career progression discriminates indirectly against the SAS doctors. However, as it was clearly a significant ethnic population, with a large female cohort, it was reasonable for me to claim that by having just one career progression route in the form of CESR, this process *indirectly discriminated* against SAS doctors. This was evidenced by the fact that

the survey data noted only 66% of SAS doctors were successful with CESR, compared with 98% for CEGPR and 100% in SRCCT and GPCCT (see Table 6.3). It is interesting to note that, overall, 39% failed in the CESR/CEGPR groups: so that, although the survey only had a 21% response rate, the findings reflect the outcomes for the total population (PMETB, 2009:7).

Table 6.3 Respondents by application outcome and certification route (PMETB, 2009:19)

	SRCCT		GPCCT		CESR		CEGPR	
Outcome	n=	%	n=	%	n=	%	n=	%
Successful	818	100	325	100	336	66	317	98
Unsuccessful	0	0	0	0	176	34	5	2
Total	818	100	325	100	512	100	322	100

The implementation of the policy, *Modernising Medical Careers* (Department of Health, 2004) via the new contract, introduced new career progression and development processes which specified, for SAS doctors, the *only* route to the post of consultant was through the CESR process. When I evaluated the outcomes via the CESR career progression route, I found secondary data that revealed a significantly smaller number of SAS doctors were obtaining CESR, compared with other grades of doctors (PMETB, 2009:19).

#### 6.10 Indirect Discrimination and the SAS Doctors

The introduction of the new contract and grades was *intended* to create more opportunities for career progression. The new policy, *Modernising Medical Careers*, was said, by the Department of Health, to offer SAS doctors more opportunities to undertake further training and progress their career (Department of Health, 2004). It was the implementation of this policy in combination with the new contract that created a career pathway that stipulated the SAS Doctors had to use the CESR route for career progression. Successful CESR applicants would then be placed on the Specialist Register held by the General Medical Council, from where they could apply for the post of consultant. Entry on the Specialist Register is a legal requirement of the *General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* (2003, [online]); it applies to



all substantive or honorary consultant posts in the NHS (but not locum consultants).

In my Literature Review, I explain indirect discrimination, and how organisations do not always anticipate the unforeseen consequences of processes, policies and procedures that they introduce. Indirect discrimination exists if it has a disproportionate adverse effect on people with a protected characteristic, as stated in the *Equality Act 2010* (2010 [online]). The protected characteristics for my research pertain to gender and race.

My study has highlighted an important finding: access only to the CESR route had a disproportionate adverse effect on SAS doctors, many of whom had at least one or possibly two protected characteristics as defined by the *Equality Act 2010* (2010 [online]). This group of doctors had a larger than average proportion of women, women from a BAME background, and men from a BAME background. Hence it could be claimed that the process was discriminating indirectly against SAS doctors.

Race and gender are both protected characteristics. Discrimination on the grounds of gender has been illegal since the *Sex Discrimination Act 1975* (1975 [online]); and, on the grounds of race (i.e. ethnicity), the *Race Relations Act 1976* (1976 [online]). Both Acts were repealed by the *Equality Act 2010* (2010 [online]) which has superseded and consolidated all previous discrimination law. As discussed in my literature review, since 2010 there has been a legal duty on all public sector bodies, such as the NHS, to advance equality and foster good relations between those who have a protected characteristic and the wider community (Equality and Human Rights Commission, 2018 [online]). The consequences for such a large organisation as the NHS, with thousands of doctors, could be substantial in economic terms; it could damage the reputation of the employer and worsen employment relations. This emphasises that there are not only ethical and legal risks, but also the risk of heavy financial cost.

I conclude that policy reform introduced by the DoH in 2004 was poorly implemented even though the DoH referred to equality, diversity, human rights and flexibility in its report. This view is supported by the Tooke Inquiry (2008)

which called for the DoH to consult more closely with the medical profession, to listen and take account of specific concerns. Moreover, the House of Commons Health Committee (2008:83) noted the DoH created 'a particularly inflexible system', nor would it listen to the concerns, i.e. voice, of the BMA. As the CESR process inter-linked with an external body, it was not clear who was responsible for ensuring equity, i.e. the GMC, the DoH or NHSE. Data unequivocally established that, with only one career route (CESR) available to SAS doctors, progression via the CESR route to Specialist Register (and consequently to the post of consultant) was less likely for this group than for doctors who had access to other career routes. This explains the *unforeseen impact* of the new contracts.

There was a further aspect regarding the inequity of treatment for SAS doctors around career progression. The Department of Health had advised the DDRB that recurrent funding of £12 million was available to trusts in England via the Deaneries to provide for SAS doctors to obtain career support, training and continuing professional development. However, there was no such funding commitment for SAS grades in Wales, Scotland or Northern Ireland. This added to an inequality of opportunity, dependent upon the country in which the doctor worked. I had ascertained this inequity much earlier, and had raised the issue each year at the Formal Oral Evidence sessions with the parties. As a result, there had been some progress in this respect, but it was exceedingly slow.

#### **6.11 Analysis of the Findings**

In formal evidence from the BMA, each year the SAS doctors would raise their concerns about the number of doctors still not assimilated onto the new contract. I had given my initial focus to the poor progression of the contract assimilation. However, the nature of the prolonged assimilation, combined with other data began to raise doubts in my mind about other aspects of the new contract. By the 2010/11 Pay Round, my investigation had produced sufficient evidence to persuade members of the DDRB and the parties that the career progression pathway was inequitable for SAS doctors. The CESR route had the potential to discriminate indirectly against applicants, when compared with other career progression routes to which SAS doctors had no access under their new career development pathway, as agreed in their new contract.

The key issue was inequity within an organisational process related to career progression. The opportunity to raise awareness of this issue presented itself through my expertise in employment legislation. My input led to a new reality, in that the parties acknowledged the career pathway for SAS doctors was potentially discriminatory. The turnkey point to bring about significant change hinged upon my attribution of indirect discrimination, which revealed itself only towards the end of my study.

My overall aim in this investigation was to understand why SAS doctors were dissatisfied and had poor morale. It had been ascertained career progression was at its core and this had created the potential to impact other related remuneration aspects such as progression to a higher pay scale. This, in turn, affected pension, discretionary awards (i.e. Clinical Excellence Awards) and training. Below, I set out my research questions and findings:

1. *What aspect(s) of the new contract was causing dissatisfaction and poor morale for the SAS doctors?*

In its formal evidence to the DDRB, the BMA highlighted: ‘the lack of career progression is an extremely important issue for SAS doctors and will only become increasingly more important’ (British Medical Association, 2009a:27). There had been a promise of change with the new contract, but the changes were either failing to materialise or were being slowed by other processes, such as job planning which had to be carried out to place a doctor on the correct pay scale before assimilation to the new contract.

After the introduction of the new policy, *Modernising Medical Careers*, and new contract for SAS doctors, the career progression route to the post of consultant was limited to just one route: CESR under Article 14. Before being considered for a consultant’s post, every doctor is required to be appropriately qualified and certified. This process is regulated by the PMETB, which is the statutory body that regulates postgraduate medical education and training in the UK. Its role is to ensure that doctors are appropriately qualified and certified for entry on to the specialist and general practice registers, as directed by *The General and*



*Specialist Medical Practice (Education, Training and Qualifications) Order 2003* (2003 [online]). The CESR route was part of the modernisation agenda and it was agreed as part of the terms and conditions of the new contract between the BMA and NHSE that there was only one career progression route for SAS doctors. Other doctors had a variety of career pathways to progress to the post of consultant) which included SRCCT, GPCCT, CCT, CEGPR.

2. *What problem(s) did the new contract for SAS doctors fail to resolve, and why?*

From September 2005 until the time of the report, there had been 4,159 CESR/CEGPR applications: 61% of were successful; 39% were not (but this does include CEGPR applications). The PMETB Survey had a response rate of 21% of applicants: 66% of CESR applications were successful and 34% were not. In the other groups, 18,184 were CCTs (either SRCCT or GPCCT) and 100% were successful. In the CEGPR route, the PMETB survey revealed 98% were successful and 2% were unsuccessful.

I believe the SAS doctors suffered a detriment by having a sole career progression route. This practice was disadvantaging the SAS doctors – a group which had significant numbers of people with the protected characteristics of gender and race. The data shows that there was a significant risk of failure in an application compared with any other route (approximately one in three would fail). In the CCT route, there was no risk of failure: in the CEGPR route it was one in fifty. The apparently neutral route served in practice to fail 34% of applicants; whereas other groups were totally or almost totally successful in their applications. I concluded this HRM practice indirectly discriminated against the SAS doctors.

My study aimed to make known the source of the dissatisfaction and poor morale. This study revealed inequity existed within the organisational structure and HRM processes. The subsequent action required was for me to use this knowledge and evidence to convince the DDRB to make formal recommendations on the issues,

and to bring the parties together for dialogue and talks so that they could agree the changes needed to achieve the above.

It has taken several years to find unequivocal answers. Through the process of reading, reflecting and interpreting little-analysed reports, I found a new level of meaning in these documents. Rather than using every report or document for its original purpose, I have interpreted the data through my professional and personal lens (Brookfield, 1998).

## **6.12 Conclusions on the Findings of the Study**

The DDRB's remit required it to make its decisions on the basis of evidence. In my Literature Review, I outlined the different perspectives on the nature of evidence. Evidence-based policy and practice can oversimplify or even ignore complex problems; I believe it caused issues when I attempted to raise concerns that challenged the current political system and culture in the NHS and DoH. I propose that the DoH, the NHSE and (initially) the DDRB did not accept that there is more than one reality, other than their own; i.e. the alternative reality of the BMA and SAS Doctors. Empirical research has been criticised in the literature for often serving the purposes of those with power whilst failing to acknowledge the reality for workers; as it has for the SAS Doctors. The literature revealed that there was a history of political or government bodies ignoring professional judgements, especially when they were contrary to a newly-introduced policy or approach; i.e. MMC. Furthermore, the top-down research-based practice advocated by the DoH was unhelpful (Rolfe, 1998). To me, this suggests there was a culture of ignoring some categories of evidence – such the voice of the SAS doctors – in favour of more traditional evidence. Therefore, in my research journey it was not a simple matter of stating that there was a problem and that it needed to be solved. The problem needed to be acknowledged in that it *existed* and was a *reality* for workers affected by it. For this reason, my study took several years to conclude and make its contribution to practice.

Further evidence in contemporary reports, such as the *Government's Response to the Health Committee Report 'Modernising Medical Careers'* (2008) highlight that the DoH has 'adopted a more conservative approach to implementing future reforms' (Secretary of State for Health, 2008:19); implying it did not take one

previously. The report also recommended that 'future consultation with the medical profession is more than a superficial exercise, that differences of opinion among consultees are reconciled where possible, and that... outcomes... are recorded' (Secretary of State for Health, 2008:18). The independent inquiry (Tooke, 2007 and 2008) into the 2007 crisis for Junior Doctors, also highlighted issues about the MMC reforms. In its response to the House of Commons Health Committee's (2008) report '*Modernising Medical Careers*' – 3<sup>rd</sup> Report of Session, Vol. 1, the Government concludes:

'it is crucial that Government... rebuilds its relationship with the medical profession at all levels... and, in consultation with them... designs the best possible structure and systems for training... NHS doctors in future' (Secretary of State for Health, 2008:1).

The literature also reminded me that, although I appreciate there are groups in our society which are excluded or marginalised, it is not a view that everyone shares. This was evidenced by the fact that I needed to discuss my *views* explicitly with other members of the DDRB who, initially, did not believe there was an issue of inequity, because there was no *evidence*. There was *evidence* but not in the traditional form, i.e. empirical. Furthermore, it was the DoH's view that the BMA should supply *more* evidence to make its case, which implied that the *voice* of the employees was insufficient. I reflect that if the DoH had accepted an alternative view, it could have resulted in change or destabilisation of the established systems of power. However, change was later forced on it by other investigations such as the *Tooke Inquiry* (2007 and 2008). It is noted that in the *Government's Response to the Health Committee Report 'Modernising Medical Careers'* (2008), the Government agreed the recommendation that there needed to be a 'wider review of clinical career structures, and the need to remove any *remaining stigma* associated with the SAS grade' (Secretary of State for Health, 2008:8). The emphasis is mine.

It is of note that the DoH and NHS appeared to take little notice of the SAS doctors' dissatisfaction as recorded in several BMA Surveys (British Medical Association, 2009a and 2009b). Furthermore, McIntosh (2010) notes the significance of *tension*; and it was just such a tension about the low morale that I discovered in the SAS doctors' oral accounts and in the employee surveys.

On a personal level, I found that I connected with, and understood, their experiences through my own experience of gender discrimination.

The career progression process brought in by the policy *Modernising Medical Careers* (Department of Health, 2004) makes it much more difficult for SAS doctors compared with other doctors, to join the ranks of the consultants. The SAS doctors agreed to new contracts but nothing changed in terms of *power*. Some aspects of the new contract did not deliver what was negotiated and agreed between the parties. Furthermore, when the BMA attempted to evidence the lack of change, there was a lacklustre response from the NHSE and the DoH. This suggests, and is supported by McNamara (2002), that there is a culture in government bodies which ignores some categories of evidence in favour of more traditional, empirical evidence. Finally, I agree with McNamara (2002) that traditional research sometimes has fallen short on the *change and improve* aspects. I would evidence my claim in that the report on career routes published by the PMETB (2008) contained the data which explicitly highlighted the CESR route was considerably less effective. No action (or *doing*) was taken until I found that report and, as a practitioner-researcher, interpreted the data to bring about change.

It was central to my personal values and beliefs that any injustice should be reversed, as I make the assumption that the negotiated contract was not intended to be unjust. However, change may not be in the interest of those in power; the journey to correct that injustice took several years. The legislative landscape also changed during these four years. In 2007, an explicit reminder was added to the remit of the DDRB to consider legal obligations on equality (Appendix 1). In 2011, the *Public Sector Equality Duty 2011* (Equality and Human Rights Commission, 2018 [online]) created by the *Equality Act 2010* (2010 [online]) came into force. These changes moved the issue from unfair to discriminatory.

Once my findings were accepted by other DDRB Members, the recommendations were written into the Review Body on Doctors' and Dentists' Remuneration's *Fortieth Report* (2012a); then sent to the Prime Minister and First Ministers for Wales, Scotland and Northern Ireland for approval. Once approved, the report and its recommendations were accepted through the lawful process of its

presentation to Parliament by the Secretary of State for Health; and subsequently published. The parties had a clear remit to discuss the content and make recommendations for change through the process of collective bargaining. I felt an overwhelming sense of satisfaction that justice had been done, and that there was now an understanding and acceptance that the career progression process had been unfair to a specific group of employees with protected characteristics. The parties had agreed to come together and work out a fair HRM process that would enable SAS doctors to progress their careers on equal terms with every other doctor in the NHS.

## CHAPTER 7. CONTRIBUTION AND IMPACT ON PROFESSIONAL PRACTICE

This chapter discusses the contribution that my research has made at both a macro and micro level, and examines the impact it has had on professional practice.

### 7.1 Overview

This publication is based around my identification of unforeseen indirect discrimination related to career progression processes used by the NHS, the UK's largest public sector organisation. The discriminatory process had the potential to affect a significant percentage of its 18,120 SAS doctors. In some countries, the impact varied, in terms of percentage potentially affected: for example, in 2007, as many as 22% of the hospital doctors in Wales were in the SAS grade.

My research identified the key issue and was formalised by the DDRB's recommendations in its 2012 Report. The key issue had been hidden under layers of other pertinent issues which were evidenced by poor morale and complaints from the doctors. This had followed the implementation of the new contracts of employment agreed between NHSE and the BMA. The drive for new contracts had been implemented by the DoH as part of its modernisation agenda. The new contracts were failing to deliver what had been agreed and promised under the terms of the collective bargaining agreement. My research challenged existing wisdom and subsequently brought influential parties together for dialogue to resolve the issue. My research added value because it has the potential to improve employee relations, provided that the parties find a solution to this long-running conflict about career progression. A solution has the potential to improve the motivation and morale of these doctors.

In the Review Body on Doctors' and Dentists' Remuneration's *Fortieth Report* (2012a), it is noted that the General Medical Council (GMC), Department of Health (DoH), NHSE and British Medical Association (BMA) agreed to work together on the key issues. Therefore, this research has made a contribution to good employment relations by bringing the parties together for dialogue. It has also

caused the GMC to review its CESR process and influence policy and process within the Postgraduate Medical Education and Training Board.

This impact was acknowledged at the highest levels of government across all four countries in the United Kingdom. The report was presented to the Prime Minister of the United Kingdom, the Secretary of State for Health and the House of Commons; the First Minister for Wales, the Minister for Health and Social Services and the National Assembly for Wales; the First Minister for Scotland, the Cabinet Secretary for Health, Wellbeing and Cities Strategy and the Scottish Parliament; and the First Minister for Northern Ireland, Deputy First Minister, Minister for Health, Social Services and Public Safety and the Northern Ireland Executive.

My research journey outlines my contribution to practice through my efforts as a sole HR practitioner to comprehend, evidence and persuade firstly, a Pay Review Body and then powerful decision-makers (the DoH, GMC and NHS) that there was an issue affecting thousands of professional doctors, which needed both investigation and change.

## 7.2 Impact on National Policy

My research has the capacity to change both social and institutional contexts (McNiff, 2002). Below, I have compiled a table of the actions and reviews taken by the parties:

Table 7.1 Actions implemented by the parties to improve career progression for SAS doctors (Review Body on Doctors' and Dentists' Remuneration, 2013:88)

Impact/action	By Whom	Duration	Value
Taking forward work to consider the concept of credentialing within medical education and careers, whereby capabilities are formally recognised at defined points of the medical career	General Medical Council		
Looking at alternative routes to general medical practitioner and specialist registration	General Medical Council		
Research commissioned about the perceptions of the CESR routes, including perceptions about the relative ease or difficulty of progression for CESR doctors compared with CCT doctors	General Medical Council		
Contributing to GMC's research about the perceptions of the CESR routes, including perceptions about the relative ease or difficulty of progression for CESR doctors compared with CCT doctors	Department of Health		
Associate Dean for SAS doctors piloting a surgical training programme with the Royal College of Surgeons for SAS doctors	Welsh Government		
SAS tutor post created within each health board/trust centrally funded via the Deanery, to lead and focus development activities locally	Welsh Government		
New funding stream from 2012-13 for Scottish SAS doctors' continuing professional development needs	Scottish Government	3 years	£1.4 m
In dialogue with the British Medical Association to explore career development opportunities	Northern Ireland Executive		
A group entitled 'Choice and Opportunity' had been tasked with the development of SAS doctors via mentoring and shadowing	Northern Ireland Executive		
Commitment to funding for SAS development was available where a clear business case was identified	Northern Ireland Executive		
Emphasised its commitment for the process of regular quality appraisals	NHS Employers		

The impact is further evidenced by the following extract from the Review Body on Doctors' and Dentists' Remuneration's *Forty-First Report*:

'This year, the Department of Health told us that the General Medical Council (GMC) was taking forward work to consider the concept of credentialing within medical education and careers, whereby capabilities



are formally recognised at defined points of the medical career, and it also updated us on the GMC's work looking at alternative routes to general medical practitioner and specialist registration. The Welsh Government reported that the Associate Dean for SAS doctors ran annual programmes of development activities with specific funding from the Deanery, and was piloting a surgical training programme with the Royal College of Surgeons for SAS doctors. An SAS tutor post had also been created within each health board/trust centrally funded via the Deanery, to lead and focus development activities locally. The Scottish Government reported a new funding stream of £1.4 million over three years from 2012-13 for Scottish SAS doctors' continuing professional development needs. The Northern Ireland Executive told us that it would explore career development opportunities through dialogue with the British Medical Association (BMA), and that a group entitled 'Choice and Opportunity' had been tasked with the development of SAS doctors via mentoring and shadowing. It also said that funding for SAS development was available where a clear business case was identified. We welcome this progress, and remind all countries of the importance of investing in the new SAS contract so that its benefits can be realised in full, and ask the parties to update us for our next review' (Review Body on Doctors' and Dentists' Remuneration, 2013:88).

### **7.3 Impact on the SAS Doctors, their Career Progression and Pay**

The SAS grades represent at least 16% of hospital doctors and make an important contribution to the delivery of NHS services. Although the parties are now aware of the issues, changes will take time to be felt by SAS doctors. It was not a surprise that the DDRB's *Forty-First Report* noted: '[the BMA's] survey showed that SAS doctors had the lowest level of motivation of all doctors' (Review Body on Doctors' and Dentists' Remuneration, 2013:88).

The DDRB noted that only 53% of SAS doctors had received an appraisal in the preceding year and asked the parties if the lack of appraisal was detrimental to pay increments. The response from NHSE was that this was rare. But the DDRB was concerned, noting the large number of doctors without appraisal and that this was 'perhaps indicative of the culture within the NHS' (Review Body on Doctors' and Dentists' Remuneration, 2013:89). It further advised that it would:

'expect modern contracts to have such mechanisms in place, with an appropriate level of protection for employees, as regular quality appraisal should be a cornerstone of both incremental pay and career development' (Review Body on Doctors' and Dentists' Remuneration, 2013:89).

This acknowledges the relationship between pay and career progression. If the process regarding career progression is changed, other processes, which are part

of the incremental pathway leading to the opportunity to apply for specialist registration, should be re-aligned.

In the 2013/14 Pay Round, the DDRB kept the momentum of this research going by explicitly reminding the parties that it required the following evidence for the next Pay Round:

- a) funding available for the career development of SAS doctors
- b) incidence of appraisals for SAS doctors.

I am no longer on the Review Body but these reports are evidence that these matters are now firmly situated within the DDRB's brief, and it continues to ask the parties to update them.

#### **7.4 Impact on the British Medical Association**

The impact on the BMA as a trade union and professional association was considerable. By 2010, the DDRB had robust evidence that the career progression route via the CESR process was potentially discriminating indirectly against SAS doctors. By 2012, with the involvement of the BMA, enquiries about the 'potential discrimination in Associate Specialists securing consultant posts via the CESR process' (Review Body on Doctors' and Dentists' Remuneration, 2012a:29) had led to the following high-level response from both the GMC and the DoH:

'the General Medical Council had commissioned research about the perceptions of the CESR routes, including perceptions about the relative ease or difficulty of progression for CESR doctors compared with CCT doctors. The Department of Health told us [DDRB] that it was contributing to this research' (Review Body on Doctors' and Dentists' Remuneration, 2012:29)

I suggest that my study verifies the concerns of the BMA. The BMA did excellent work in terms of its Health and Economic Research Unit's surveys, and its persistent lobbying to have the concerns of its members taken seriously. This underlines its commitment to its members and the profession. However, its claims were not taken seriously until my involvement.

## **7.5 Impact on Employee Relations**

My research has helped towards the resolution of a long-running disagreement between SAS Doctors (formally represented by their trade union, the BMA), their employer (the NHS formally represented by the group NHSE) and the DoH. The research has challenged existing wisdom around the fairness of a career route, and has brought the parties together for formal dialogue with the GMC.

## **7.6 Impact on the NHS and NHS Employers**

The NHSE made little comment about the recommendations but emphasised its commitment to regular quality appraisals.

## **7.7 Impact on the DDRB**

I suggest that my findings have improved the practice of the Review Body on Doctors' and Dentists' Remuneration, as gender and ethnicity are now reported and evaluated (Review Body on Doctors' and Dentists' Remuneration, 2017:85).

## **7.8 My Contribution to Scholarship and the Body of Knowledge**

This interpretive study provides my contribution to scholarship and knowledge through my use of qualitative research to deconstruct and reveal the often invisible, but no less real, complexities of power relations within HRM and its practices. These are complex issues related to inequitable practices, unjust structures and dominant barriers (Fenwick, 2005:235). My case study's identification of indirect discrimination denaturalises organisational power; furthermore, it highlights the managerial perspective with which HRM continues to align itself (Legge, 2005; Delbridge and Keenoy, 2010). The HRM practice of career progression indirectly discriminated against the SAS doctors, who predominantly possessed the legally protected characteristics of female gender and race. It supports the view that power inequalities exist around the variables of gender and race and that they are probably institutionalised (Kaira *et al.*, 2009; Delbridge and Keenoy, 2010; Pope, 2017) and, as in this study, are reinforced by HRM practices and processes. Organisational change to modernise the NHS has

not led to the espoused gains for SAS doctors but rather maintained managers' control over discourses that have implications for their power (Diefenbach *et al.*, 2009; Pope and Burnes, 2013; Brookfield, 2014).

## **7.9 My Contribution to Professional Practice**

By its nature, my research will have an effect on professional practice in HRM and employee relations. It has made known an intellectual problem of power and inequity within an organisation which believed it was operating to the highest standards of equality. It is possible that other organisations unknowingly have processes which discriminate indirectly; hence, this work has professional value as a case study. It identified the discriminatory aspect of the career pathway for SAS doctors in the NHS, and this resulted eventually in the parties' return to dialogue. As a consequence, actions have been taken by the General Medical Council, Department of Health and others to remedy the inequality within the career progression process; thereby improving professional practice and potentially improving the working lives of over 18,000 SAS doctors. My study highlights that for the employment relationship to be mutually beneficial, the competing perspectives and multiple realities between managers and employees must be acknowledged (Kaufman, 2015). Finally, the neutrality of HR should not be assumed, as it is transitioning from a professional and ethical concern for people, to a functional and managerial-aligned focus on providing a business service (Delbridge and Keenoy, 2010).

Through the medium of this case study, I have shown that I am able to make informed judgements on complex issues, i.e. HRM practices and discrimination, in my specialist field. There was an absence of data in the early stages of my study, but I communicated my ideas to the audience of the DDRB and promoted an understanding of the complexities of indirect discrimination. Conclusions were communicated as recommendations by the DDRB in the published body of work (see Appendix 8). The reports were approved by the Prime Minister and First Ministers for approval, before presentation by the Secretary of State for Health to the House of Commons.

## CHAPTER 8. MY CONCLUSIONS

The eighth chapter draws together my conclusions, examines the links to the literature, and sets out my reflections. I utilise elements of Brookfield's (1998 and 2014) work to reflect on the autobiographical nature of my Context Statement. I discuss how my critical reflection has increased my understanding of the relationship between my academic and professional identities, and how writing this work has reconceptualised my learning about myself (Eastman and Maguire, 2016:358).

### 8.1 My Context Statement in relation to the Literature (lens one)

Brookfield (1998:197) suggests using a lens of 'theoretical, philosophical, and research literature'. My reading of the literature highlighted the importance of factors which maintain a motivated workforce: the employee voice, justice in the workplace, and the protection of employee rights (Klaas *et al.*, 2012; Wilkinson *et al.*, 2014; Kaufman, 2015). Brown's (2001:115) model has shown the interrelated nature of Pay to other organisational processes; and that reward strategies should be more inclusive. This study supports that view and suggests that discrimination is an additional, interrelated dimension, whose consideration should be mandatory when effecting organisational change to process or practice. Organisations should ensure there is internal and external alignment between policy, process, and *intention*.

My study also revealed there is a delicate line between how organisations interpret discretionary and mandatory obligations. It was only when I had evidenced the legal obligation (*Equality Act 2010*, 2010 [online]), rather than the *intention* of the new contract, that the parties responded. My findings note the difference between what the dominant powers of the NHSE and the DoH consider acceptable evidence, versus the SAS doctors' reality, as presented through their *voice* (McNamara, 2002; McIntosh, 2010).

My study has a philosophical underpinning based on Critical Theory and its role in changing the world. My advocacy approach was based on the methodology of Shield's (2012) *critical advocacy-oriented research*. My study ensured that the

parties' understandings changed, and it led tactical and strategic change as highlighted by the parties' responses set out in Table 7.1. This study illustrates the effectiveness of Shield's (2012) methodology: I advocated for the SAS doctors and influenced NHS practices that caused marginalisation and exclusion. Ultimately, my research reveals the effect of power, politics and inequity in society: how it can indirectly affect the equality of opportunity for employees, even with equality legislation in place (Tyson, 2006; Brookfield, 2014).

## **8.2 The Parties (lens two)**

Brookfield (1998:197) suggests using a lens of 'the learners'. Through the medium of the DDRB, I engaged all stakeholders (DDRB, the parties) regularly with my ongoing findings and resultant implications (Shield, 2012). It was significant that the voice of the SAS doctors was disregarded for so long as the BMA's evidence clearly indicated a problem. In the interests of maintaining a positive employment relationship, the NHSE or the DoH should have looked further, but the SAS doctors' voice and reality were ignored. However, the parties agreed to start a dialogue with the BMA, and this includes the General Medical Council which has regulatory responsibility for doctors' career progression. It will take time for changes to work their way down to the SAS doctors. This is why it is not surprising that motivation was noted to be the lowest of all the doctors in the BMA survey (Review Body on Doctors' and Dentists' Remuneration, 2013:88).

## **8.3 Colleagues' Perceptions (lens three)**

Brookfield (1998:197) suggests using a lens of 'our colleagues'. Nothing we do is in isolation. I have had the good fortune to meet and work with brilliant and committed people. The DDRB meetings transformed me and my thinking; sometimes we learn more from those who need persuading to our views than from those who agree with us. I thank those who have agreed with me as sincerely as those who have not.

The DDRB proved useful, once I had clarity on the issue. It provided an opportunity to debate different positions; to have my emergent views questioned and critiqued. The strict protocol of the DDRB really challenged me and my view

of the world. Initially, colleagues advised that I was mistaken; there was no evidence. Yet I kept on my research journey, as I felt there was more to uncover and it would eventually make sense. The DDRB's Chair was invaluable as my critical friend; he critiqued my ideas constructively and encouraged my alternative perspective. He advised me to find independent data that would make these views irrefutable. And I did.

#### **8.4 My Autobiography and Impact of the Research on Self (lens four)**

As I stand on the 'bridge of this ship' which is my doctorate, I did not imagine back in 2007 that indirect discrimination was both the problem and the solution to the career progression issues of the SAS doctors. In writing this Context Statement, I have reconceptualised my practice – both at professional and theoretical levels. The journey through the philosophy of my research has enabled me not only to understand what I am doing but also, on an epistemological level, how and why I am doing it.

I have reflected that, were it not for my identification of the protected characteristics of this group, would anything have changed? If this group had consisted mainly of employees without protected characteristics, there would have been no legal imperative to review or change the career progression process. I discovered that a significant number of doctors were failing in their application for a CESR. This in itself is not discriminatory, but proved to me that neither the negotiated intention but nor the *spirit* of the contract was fulfilled. I reflected that anything else I could find to encourage the NHSE to fulfil its obligation, would come from my HRM expertise: it obliged with the answer of *indirect discrimination*. It is a particularly challenging concept for many employers and those without an HRM background. My professional skills, legal knowledge, and sensitivity from my own experience of gender discrimination make a powerful combination. It enabled me to identify and communicate the inequity to my fellow Members: they agreed unanimously with my findings, and that these should be the DDRB's recommendations. The strength of my methodology is my use of independent secondary data which is irrefutable, and gave these findings credibility to the DDRB and to the parties.

From the outset, I hoped that if my research were to achieve impact, it would be a step towards making society more equal. My research is linked to my values and the desire to confront injustice; in this study, it is the injustice of a new process brought in by the policy of modernisation, which had compromised the SAS doctors' career progression and, therefore, pay.

My intention was to understand, examine and then educate, so that changes could be made with general agreement and co-operation. Reflection was a key aspect of this research process. In relation to my development, Mezirow (1991) identifies three forms of reflection: content, process, and premise. Initially, I focused on content because I was reflecting on the issues for the SAS doctors. As I started to make sense of the phenomenon, I became more aware of the strategies and processes of the DoH and the NHS, i.e. process. It is only as I have written this Context Statement that I have engaged with premise because I am critiquing my underlying assumptions and perspectives.

It has been a cathartic experience to write about this series of events, and review the literature and my amassed reports. It is an opportunity to re-live the experiences, to check over areas where I had doubts, to re-think what I did and how I did it. I have also searched the literature to find more data and theory and, thereby, deepen the perspective and insight that I was originally afforded. I arrived at my research conclusions by patiently collecting a plethora of information on a complex issue in my specialist field; by reflecting on the data that emerged; and how its relationship to the main problem was formulated. At times, I was a detective; sourcing information, piecing together what I had discovered and making informed judgements. The process with the DDRB took four years, as there was an absence of complete data, but gradually it revealed small insights and clues which would answer one question, only to pose another.

I have developed as an academic through undertaking this doctoral level programme. My reflexivity was with me when I began this journey. However, it has deepened and become transformational. I was always confident in my professional skills and knowledge, but I have increased confidence in my research skills. I have linked my writing to my ontological and epistemological stance; I have examined my underlying assumptions; I have searched for minutiae to



evidence this study. My transformative journey has already enabled me to take on new academic roles.

I have a new perspective on writing and I aim to balance description with insightful analysis. I am more conscious that my interpretations are based on my values. As I have written, new insights and connections have revealed themselves because, as Eastman and Maguire explain, it is a 'transformative practice' (2016:357). My coaching skills played an important part; not only in the self-examination of reflection but also in the research. Fillery-Travis and Cox (2014:453) highlight the importance of coaching; much of this study involved personal interaction, i.e. DDRB meetings, oral evidence sessions and field visits. There was a significant amount of reading and synthesis, but in combination with the linguistically rich, personal interactions, my knowledge became transformed.

## **8.5 Use of the Research Findings**

Beyond this study, my findings give an insight to any organisation that changes its processes but does not consider if there are groups of employee who have a protected characteristic, and would suffer disproportionately. It is an example from a well-known organisation (NHS) that most will access, so I use these findings to teach students. I am using the deeper understanding of self to optimise student engagement. Although idiographic in its focus, I have been able to use this knowledge in other contexts.

## **8.6 Future Research**

I have enjoyed producing this Context Statement and I feel more confident to disseminate my work through publications. I am interested in completing a case study for an academic journal, and I aim to write up other aspects of the investigation, which focus on pay and HRM practices. I would like to assess how the new contract is working for the SAS doctors, through an analysis of the years 2013 to 2018.

## 8.7 Conclusion

I have read the Review Body on Doctors' and Dentists' Remuneration *Forty-First Report* (2013) and know this matter is now identified clearly. It is truly heartening to read the responses from the Department of Health, the General Medical Council and the four Governments of the UK.

To conclude, I see the world through the lens of my gender, my age and my sexuality; this is my bias. I propose it is good organisational and HRM practice to seek understanding through the voices of those who understand and live their reality, i.e. employees. Since discrimination is best understood by the recipient, leaders and HR practitioners should be hyper-vigilant by embracing the voices of employees, respecting their realities, and utilising dialogue to unlock their insight.

My advocacy approach aimed to address inequity and injustice. Shield (2012:6) writes about the 'public intellectual who takes a reasoned, moral and public stance based on the information and understanding one has'. My prior HR experience, my specialism in Pay, my membership of the DDRB, and my academic role all combined to give me the opportunity and ability to take my stance. At times, I felt like a lone voice but I felt reassured by Said (1994:13):

'public intellectuals *should* ask embarrassing questions, confront dogma, be people who cannot easily be swayed by governments and whose *raison d'être* is to represent all those people who are forgotten... intellectuals should stand up for the universal principles of justice and freedom and... fight courageously against those who would subvert them'.

I concur wholeheartedly.

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## Glossary of Terms

BMA	British Medical Association
BME	Black and Minority Ethnic
BAME	Black, Asian and Minority Ethnic
CCT	Certificate of Completion of Training
CESR	Certificate confirming Eligibility for Specialist Registration
CEGPR	Certificate confirming Eligibility for General Practitioner Registration
CIPD	Chartered Institute of Personnel and Development
DDRB	Review Body on Doctors' and Dentists' Remuneration
DoH	Department of Health (latterly known as the Department of Health and Social Care)
EMEA	Europe, Middle East and Africa
GPCCT	General Practitioner Certificate of Completion of Training
HCHS	Hospital and Community Health Services
HO	House Officer
HRM	Human Resource Management
IPD	Institute of Personnel and Development
IPM	Institute of Personnel and Management
JAC	Judicial Appointments Commission
MMC	Modernising Medical Careers
NHS	National Health Service
NHSE	National Health Service Employers
OME	Office of Manpower Economics
PMETB	Postgraduate Medical Education and Training Board
QRRNs	Queen's Regulations for the Royal Navy
SAS/NCCGs	Staff and Associate Specialist/Non-Consultant Career Grades
SAS	Speciality Doctors and Associate Specialists
SHO	Senior House Officer
SpR	Specialist Registrar
SRCCT	Specialist Register Certificate of Completion of Training

## APPENDICES

### Appendix 1 Revised terms of reference for the 2008/9 Pay Round

Extract from a letter from Secretary of State for Health, the Right Honourable Alan Johnson, MP, formally notifying the Pay Review Body of the revised terms of reference for the 2008/9 Pay Round

OH Department  
of Health

#### REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION TERMS OF REFERENCE – July 2007

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services in the Welsh Assembly Government and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- the need to recruit, retain and motivate doctors and dentists;
- regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;
- the funds available to the Health Departments as set out in the Government's Department Expenditure Limits;
- the Government's inflation target;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services of the Welsh Assembly Government, the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive and the Prime Minister.

DG2807

## Appendix 2 Letter of thanks from the CEO of the Judicial Appointments Commission

Letter of thanks from Nigel Reeder, OBE, Chief Executive Officer of the Judicial Appointments Commission



**PERSONAL**  
Ms Katrina Easterling

**Nigel Reeder OBE**  
Chief Executive  
Judicial Appointments Commission  
1<sup>st</sup> Floor  
Steel House  
11 Tothill Street  
London  
SW1H 9LH

T 0203 334 0571  
F 0203 334 0130  
E [nigel.reeder@jac.gsi.gov.uk](mailto:nigel.reeder@jac.gsi.gov.uk)

<http://jac.judiciary.gov.uk>

---

24 October 2012

Dear *Katrina,*

In the six years since the creation of the JAC, you have been part of a process that has resulted in the interview of almost 10,000 candidates, for what is now approaching 3,000 judicial posts in areas as diverse as agriculture and drainage through to appointments to the most senior judicial posts in England and Wales.

In each case you have shown acumen, expertise and sound judgement as a panel member to recommend only the best candidates for each judicial position. You have made a significant contribution to the judicial appointments process and the maintenance of judicial independence and your time, effort, and hard work over this period are very much appreciated.

I should therefore like to thank you both personally, and on behalf of the Chairman, Commissioners and staff of the JAC for all that you have done and for the way in which you have done it. Please accept my thanks and very best wishes for the future.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Nigel Reeder', with a horizontal line drawn underneath it.

**Nigel Reeder OBE**  
Chief Executive Officer

### Appendix 3 Letter of thanks from the Secretary of State for Health

Letter of thanks from the Right Honourable Andrew Lansley, CBE, MP, Secretary of State for Health

*From the Rt Hon Andrew Lansley CBE MP  
Secretary of State for Health*



POC1\_676565

Ms Katrina Easterling

*Richmond House  
79 Whitehall  
London  
SW1A 2NS*

*Tel: 020 7210 3000  
Mb-sofs@dh.gsi.gov.uk*

- 6 FEB 2012

*Dear Ms. Easterling,*

#### **REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION (DDRB)**

As you know, your appointment as a member of the DDRB will end on 31 March 2012. By that stage, you will have served two terms which is the maximum permitted.

I am writing to thank you for your work as a member of the DDRB since 2005. I am very grateful to you for the work you have undertaken over the past six years. I know that the Chair and your fellow members have greatly appreciated the valuable contribution you have made to the working of the review body.

I wish you the very best for the future.

*Yours ever,*  
A handwritten signature in black ink, appearing to read 'Andrew Lansley'.

**ANDREW LANSLEY CBE**

#### Appendix 4 Pay Scales for SAS grade doctors and consultants

Pay scales for SAS grade doctors after the introduction of the new contract, as at 2012  
(Source: Review Body on Doctors' and Dentist' Remuneration, 2012:62-63)

	United Kingdom
	£
Specialty doctor <sup>14</sup>	36,807
	39,955
	44,046
	46,239
	49,398
	52,546
	55,764
	58,983
	62,201
	65,419
	68,638
Associate specialist (2008) <sup>15</sup>	51,606
	55,754
	59,901
	65,378
	70,126
	72,095
	74,665
	77,235
	79,805
	82,375
	84,948



	United Kingdom
	£
Associate specialist (pre-2008)	37,694
	41,687
	45,678
	49,670
	53,663
	57,655
	62,927
	67,496
<i>Discretionary Points</i>	<i>Notional scale</i>
	69,392
	71,866
	74,339
	76,813
	79,286
	81,762
Staff grade practitioner (1997 contract, MH03/5)	34,100
	36,807
	39,514
	42,221
	44,928
	48,115
<i>Discretionary Points</i>	<i>Notional scale</i>
	50,342
	53,048
	55,755
	58,462
	61,169
	63,877
Staff grade practitioner (pre-1997 contract, MH01)	34,100
	36,807
	39,514
	42,221
	44,928
	47,634
	50,342
	53,048



Pay scales for Consultants, as at 2012

(Source: Review Body on Doctors' and Dentist' Remuneration, 2012:60-61)

England, Scotland and Northern Ireland	
	£
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds)	74,504
	76,837
	79,170
	81,502
	83,829
	89,370
	94,911
	100,446
<i>Clinical Excellence Awards<sup>6</sup></i>	
	England and Northern Ireland <sup>7</sup>
	£
	2,957
	5,914
	8,871
	11,828
	14,785
	17,742
	23,656
	29,570
	35,484 <sup>8</sup>
	Scotland <sup>10</sup>
	£
<i>Discretionary Points<sup>9</sup></i>	3,204
	6,408
	9,612
	12,816
	16,020
	19,224
	22,428
	25,632

	<b>Wales</b>
	£
Consultant (2003 contract, Wales)	72,205
	74,504
	* 78,350
	82,818
	87,918
	90,827
	93,742
<i>Commitment Awards<sup>11</sup></i>	<i>Wales<sup>12</sup></i>
	£
	3,204
	6,408
	9,612
	12,816
	16,020
	19,224
	22,428
	25,632
	<b>United Kingdom</b>
	£
Consultant (pre-2003 contract) <sup>13</sup>	61,859
	66,285
	70,712
	75,138
	80,186



19 Apr 2007

HOSPITAL  
Doctor

SAS CONTRACT

# SAS doctors start pressure group

Nina Jacobs

A GROUP of disaffected staff and associate specialist grade (SAS) doctors at a Birmingham hospital have formed a pressure group to lobby the BMA and Government over the new SAS contract.

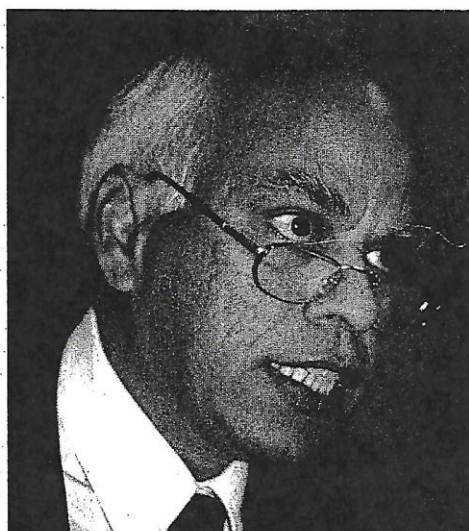
The National Staff and Associate Specialists Group (NSASG), formed at the Good Hope Hospital, says it was forced to act after feeling 'let down' by the BMA whose contract negotiations with the DoH have left its members feeling 'disheartened'.

SAS doctors are due to be balloted in June over the new contract which has been hampered by severe delays despite 18 months of negotiations.

Dr David Kinshuck, an associate specialist in ophthalmology and founder member of NSASG, said he hoped to secure better conditions for SAS doctors than those currently offered.

Dr Kinshuck told *Hospital Doctor*: 'The new contract blocks progression between grades and does not really recognise our specialist expertise.'

He said NSASG was also



MR MOHIB KHAN 'we are aware there is a great deal of dissatisfaction'

concerned the new contract would alter SAS doctors' working hours.

The group, believed to be the only one of its kind, has set out its objectives on a new website from where it hopes to attract enough membership to hold an inau-

gural meeting later this year.

Among its key aims are to create a career structure so members can progress from staff grade to associate specialist; to ensure high achieving members reach consultant posts by means of Article 14; to pressurise the BMA to

support these measures and carry out effective negotiations with the DoH.

Mr Mohib Khan, chairman of the BMA's staff and associate specialists committee, said the creation of NSASG was a 'reaction' to constant delays over the new contract.

He said: 'We are aware that there is a great deal of dissatisfaction out there because of the Government's continued stalling tactics on new contract proposals.'

'The BMA has negotiating rights for SAS doctors and would encourage frustrated doctors to get involved with the BMA to make their voices heard.'

Mr Awani Choudhary, former lead negotiator for the BMA's staff grade and associate specialists committee, said he was not surprised the pressure group had been formed.

He said: 'I think it's a good idea. These people have put their heads above the parapet - nobody is going to give them anything unless they ask for it.'

[www.nsasg.org.uk](http://www.nsasg.org.uk)

BMA NEWS 28 April 2007

## SAS leaders' fury boils over as ministers stall on deal

EXCLUSIVE  
BY POLLY NEWTON

BMA NEGOTIATORS are preparing to confront the government over SAS contract approval delays as there is 'no result in sight'.

As *BMA News* went to press, the BMA staff and associate specialists committee negotiating team was poised to debate its strategy amid mounting anger over lack of progress.

SASC chair Mohib Khan said: 'We have had two years of intense hard work and at the end of it all there is no result in sight. I am extremely annoyed by the current attitude of the government.'

The contract proposals were submitted to the Department of Health last November following 18 months of negotiating between the BMA and NHSE (NHS Employers).

The government asked for more information about costs and in February sought a last-minute guarantee that taxpayers would not be asked to foot unexpected bills associated with the contract.

In response, the BMA/NHSE underlined the strength of their financial planning but stressed they could not account for every possible circumstance. Eight weeks on there has been no

government reply, despite repeated requests for information from BMA council chair James Johnson and others.

Until the contract proposals are cleared by the public sector pay committee the BMA cannot begin the process of balloting all SAS doctors.

Although the SASC is formally adopting a neutral stance towards the contract, Mr Khan said he wanted SAS doctors to be aware the deal had shortcomings.

'We negotiated in good faith as good honest negotiators looking at all sorts of possibilities about how we

could improve this grade.

'It has not been possible to achieve all the improvements we would have wished and we have got as far as we could go within the context of our negotiations,' he told *BMA News*.

Mr Khan added: 'The deal is not what we hoped for when we embarked on the contract negotiations.'

For example, he said, the proposed closure of the associate specialist grade would reduce career progression opportunities and pay for out-of-hours work may not be as favourable for all doctors.

The DH has said a decision is expected 'within weeks'.

STAFF & ASSOCIATE  
SPECIALISTS  
CONTRACT

# Ministers accused of undermining contract talks

STAFF &amp; ASSOCIATE SPECIALISTS

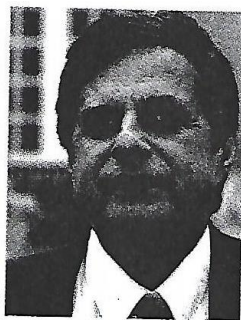
BY POLLY NEWTON

MINISTERS HAVE undermined the entire NHS negotiating process by blocking SAS contract proposals, says a key figure in the talks.

In a letter to health secretary Alan Johnson, BMA SASC negotiating subcommittee chair Ashok Pathak criticises the government for failing to accept assurances about the cost of the proposed deal.

Both the BMA and negotiators for NHS Employers have offered 'every reassurance' about the accuracy of their financial calculations, Dr Pathak writes.

'SAS committee negotiators believe that the government's apparent lack of faith in, and support for, the financial aspects of the contract proposals and lack of will to release them for



**PATHAK: letter to Alan Johnson attacks the government's 'lack of will'**

balloting by the profession and potential implementation undermines the negotiating rights and mandate given to each party and the NHS negotiating process altogether,' he writes.

Dr Pathak says SAS negotiators feel they have done 'everything they possibly can' to cooperate so that the contract can be released for a ballot.

'The SAS committee feels that there is no more to be gained from continuing discussions with the government that have so far proved fruitless and that it is now time to seek the views of all SAS doctors and dentists so that we can determine an alternative way forward.'

His letter follows the decision by the BMA staff and associate specialists committee to abandon talks on the contract, which was submitted to the DH (Department of Health) last November but has yet to be approved by the public sector pay committee.

The Treasury failed to meet the August 17 deadline set by the BMA for a meeting with senior ministers or the release of the contract for a UK-wide ballot of SAS doctors.

The SASC is now planning a conference on

November 5 at which grassroots SAS doctors will be asked their preferred course of action. A BMA survey will also seek their views on the contract and the way forward.

In the letter, Dr Pathak adds that SAS doctors are the last group of NHS healthcare workers to be offered a modernised contract and 'continue to be overlooked'.

In a letter to BMA council chair Hamish Meldrum on August 16, the day before the deadline set by the SASC for government action, chief secretary to the Treasury Andy Burnham urged 'continued patience'.

'Given concerns about recent NHS pay contracts, you will understand that the government will wish to be reassured that costs do not overrun and that benefits would be delivered from any contract,' he wrote.

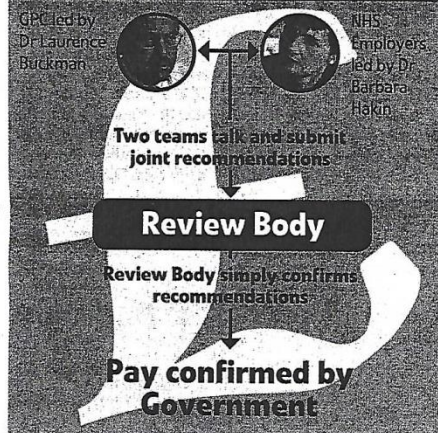


REMUNERATION

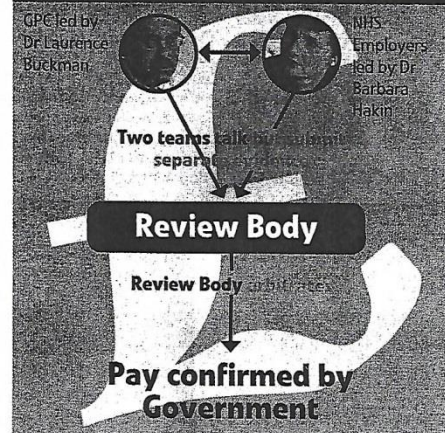
DOCTOR - 11 SEPT 2007; P1

# Pay negotiations under way again

## How pay was decided



## How pay will be decided



Cathy Comerford

PAY TALKS between GP leaders and NHS Employers (NHSE) have resumed after the nine-month impasse which led to GPs receiving a 0% pay award this year.

But despite the return to the negotiating table, the two parties will submit separate evidence to the Review Body in future, GPC chairman Dr Laurence Buckman said.

'We found doing things jointly exceedingly difficult,' he added. 'We will submit separate evidence even if we agree on everything.'

This year the Review Body will simply adjudicate on the contract as it stands, but by

the following year it will consider all potential changes submitted by the two teams.

Since the introduction of the new GMS contract in 2004, both sides have submitted joint evidence to the Review Body for a virtual rubber-stamping.

However, last year, after talks between the two parties broke down over 'efficiency savings' desired by NHSE, the GPC reverted to the old system of submitting separate evidence, asking for an inflationary uplift across all areas of the contract.

Then-chairman Dr Hamish Meldrum described the resulting announcement of the 0% award to GPs for 2007-08 as 'a

black day for general practice'. He also queried NHSE's mandate to negotiate on pricing elements of the contract.

The DoH argued that the Review Body no longer had a role in deciding GP pay and it was not feasible for it to study all aspects of GP income in order to recommend on pay.

But the Review Body said it would continue to recommend GP pay unless the parties were 'unanimous in asking it not to do so'.

It asked all parties to agree on whether it should recommend on GMS GP pay for 2008-09 by the beginning of this next round.

A DoH spokesman told *Doctor* this week: 'As was the

case last year, NHS Employers and the GPC will be presenting separate evidence to the Review Body. This is normal.'

He refused to comment on NHSE's mandate to negotiate pricing of the contract, 'as this would compromise negotiations'.

An NHS Employers spokeswoman said: 'We now have a mandate from the DoH to explore changes to the contract for 2008-09 and have met with the BMA recently to talk about resuming negotiations.'

She said it would submit evidence on GP pay in time for this year's round.

ONLINE FIRST  
WWW.DoctorPortal.co.uk



# Employer error slows SAS contract process

EXCLUSIVE BY  
JENNIFER TRUELAND

SAS DOCTORS in Scotland wanting to move to the new contract may have to wait a year longer than those in the rest of the UK, the BMA has warned.

Delays in awarding optional and discretionary points mean offer letters might not go out until next year in some NHS board areas.

BMA Scottish staff and associate specialists committee chair Sally Winning, who was re-elected last week, said the situation was unacceptable.

'NHS boards have known this was coming for a long time, yet some employers are up to three years behind with awarding points,' she said.

'It's very frustrating and means that we could be a year behind England in moving to the new contract.'

The Scottish government had instructed NHS boards to complete the process of awarding points—including those payable from April

2008 — by the end of August, so that doctors could make informed choices about moving to the new contract.

But Scotland's 14 NHS boards are all at different stages of the process, and none are in a position to send out expression-of-interest letters.

In spite of the delays, SAS doctors will still receive back pay to April 2008 and retrospection, such as seniority payments, from April 2007.

But Dr Winning said: 'This affects all SAS doctors in a board area whether or not they are eligible or have applied for points.

'Some boards are further ahead than others, which just shows that there are some good employers and some poor ones.'

A Scottish government spokesperson acknowledged the problem, but added: 'A significant part of this was due to the need for all four UK countries to go through their agreed procedures for ratification of NHS pay agreements.

'The Scottish government health directorate, NHS Scotland employers and BMA Scotland have been working together over the past few months to agree on the specific arrangements that will apply in Scotland.

'These talks have been positive and constructive, and we are hopeful that the new contract will be introduced in the near future in Scotland.'

● Separately, employers in Scotland have dropped an insistence that staff grade doctors hoping to be regraded as associate specialists have to show they have worked the equivalent of ten years full time.

NHS boards have agreed that doctors who have been turned down solely on account of not meeting that criterion should be regraded and that regrading should be applied retrospectively.

Dr Winning said: 'This is good news and we'd like to urge doctors who feel they have been turned down unfairly because of this issue to approach their employers to have it resolved.'

## Appendix 6 Formal permission from Ron Amy MBE, Chair of the DDRB, 2007-13

Katrina.Easterling

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**From:** Katrina Easterling [mailto:k.easterling@bham.ac.uk]  
**Sent:** 05 April 2018 12:24  
**To:** Ron Amy  
**Cc:** Katrina.Easterling  
**Subject:** Re: Katrina's Thesis

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Many thanks, Ron, for confirming your permission. FYI, this email will be placed in an Appendix pertaining to permissions, but I will remove your email address. Thank you for your good wishes!

Best wishes  
Katrina

On 4 Apr 2018, at 11:57, Ron Amy [mailto:ron.amy@bham.ac.uk] wrote:

Dear Katrina

I have no problem being named in your thesis or to you including the quote from your performance review.

All the very best.

Ron

Sent from my iPhone

On 4 Apr 2018, at 11:52, katrina.easterling [mailto:k.easterling@bham.ac.uk] wrote:

Dear Ron

Many thanks for your good wishes. I am at the 'business end' of things now, with editing and proof-reading nearly complete.

I do need to ask, formally, for your permission to use your name in my thesis. FYI, I have only used it in my Acknowledgements section and elsewhere it only refers to Chair of the DDRB. I have also used a sentence that you wrote and we agreed, from my Performance Management feedback in 2009. As this is a document you originated, I do need to ask your permission to use the quote. Below is the excerpt I have written, using the quote:

It is of note that the Chair of the DDRB commented in written feedback to me that I had a different way of looking at the world, which gave the DDRB an alternative perspective: 'Katrina often raises issues and challenges which others have not considered.' (Amy, 2009:1).

I am very happy to give you any more information. For my part, it has been very illuminating to reflect back on those times and the SAS doctors. Your approach to the role of Chair and your willingness to be open to different perspectives was very important. You let me run with ideas based on my professional knowledge and expertise, but you also guided me in the 'politics' of the situation and challenged me constructively to find the evidence. I learned a lot from you. Hence why you are in my acknowledgements. A sincere and grateful thank you.

Best wishes  
Katrina

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## Appendix 7 RKE Ethics Approval

Ethics Approval from Professor Alan Murray; confirmed by RKE Committee Jan 2016 (8 pages)

Form B, RKE Ethics proforma



### FORM B, RKE ETHICS PROFORMA – Staff and Students

#### GUIDELINES

Before completing this proforma, please refer to the University Research and Knowledge Exchange Ethics Policy which will provide further information and also clarify the terms used.

Please note that it is your responsibility to follow the University's Policy on the ethical conduct of research and knowledge exchange and any relevant academic or professional codes of practice and guidelines pertaining to your study. This includes providing appropriate information sheets and consent forms, and ensuring confidentiality in the storage and use of data. The checklists will identify whether ethics approval is required and at what level.

This Ethics Proforma should be completed for each research, study or knowledge exchange project involving human participants or data derived from directly identifiable individuals. This should be done before any potential participant is approached to take part in the research/study.

The questions in this proforma are intended to guide your reflection on the ethical implication of your research. Explanatory notes can be found at the end of this proforma and by hovering the mouse over the asterisks (\*).

If any aspect of the project changes during the course of the research, you must notify the Faculty RKE Committee of the RKE Ethics Committee, whichever is relevant, by completing Section 6 of this proforma.

Please use Section 10 to append consent/ participant information forms or any other documentation that may be relevant to assess your application.

#### BEFORE YOU START: DETERMINING WHETHER YOU REQUIRE ETHICAL APPROVAL

A. Does the research involve living human participants, samples or data derived from identifiable individuals?

☒ Yes \*

☐ No \*

A.1. Does your research require external ethics approval (e.g. NHS or another institution)? (See note 1)

☐ Yes \*

☒ No \*

B. Does the research involve the use of animals?

☐ Yes \*

☒ No

C. Does the research involve the use of documentary material not in the public domain?

☐ Yes \*

☒ No

D. Does the research involve environmental interventions?

☐ Yes \*

☒ No \*

(Revised Jan 2015)

Page 1 of 22

**SECTION 1: PERSONAL DETAILS**

**1.1. Your name:** Katrina Easterling

**1.2. Your Department:** Department of Applied Management, Faculty of BLS

**1.3. Your status:**

☐ Undergraduate Student

☒ Staff (Academic)

☐ Taught Master

☐ Staff (Professional Services)

☐ Research Degree student

☐ Other (please specify):

**1.4. Your Email address:** katrina.easterling@winchester.ac.uk

**1.5. Your Telephone number:** 01962 827382

For students only:

**1.6. Your degree programme:**

**1.7. Your supervisor's name:**

**1.8. Your supervisor's department:**

**SECTION 2: YOUR RESEARCH**

**2.1. Project title:** : Building an evidence based case for policy change: the unintended consequences of indirect discrimination in new NHS employment contracts on employment relations and its impact on the career development and remuneration of a specific group of NHS employees..

**2.3. Expected start date:** 1 April 2016

**2.4. Expected completion date:** 31 March 2018

**2.5. Expected location:** ? Winchester, UK

**2.6. If outside the UK, state country:** ?

**2.7. Has ethical approval been obtained at the host country? \*** ☐ Yes ☐ No

**2.8. If not, why not?**

**2.9 If the research is taking place outside the UK, is it covered by the University's insurance, or has the researcher obtained an appropriate insurance (e.g. travel insurance)?** ☐ Yes ☐ No

**2.10. Does the research include risks or other factors that might cause it to be excluded from coverage by the University insurers? (see note 5)** ☐ Yes ☐ No

**2.11 Has funding been sought for this research?** ☐ Yes ☒ No

**2.12. If so, where have you applied for funding?**

**2.13. Has the funding been granted?** ☐ Yes ☐ No ☐ Pending

**2.14. Other collaborators \***

**SECTION 3: DETERMINING THE LEVEL OF ETHICAL SCRUTINY: ETHICS CHECKLIST 1**

Please mark with an "X" as appropriate	YES	NO
Does the research involve individuals who are vulnerable or unable to give informed consent? (e.g. vulnerable children, over-researched groups, people with learning difficulties, people with mental health problems, young offenders, people in care facilities, including prisons)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does the research involve individuals in unequal relationships e.g. your own students?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Will it be necessary for participants to take part in the study without their knowledge and consent at the time? (e.g. covert observation of people in public places, deception)? (see note 2)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Will the study involve discussion of sensitive topics? For example (but not limited to): sexual activity, illegal behaviour, experience of violence or abuse, drug use, etc.). (Please refer to the Research Ethics Policy, XXX).	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a risk that the highly sensitive nature of the research topic might lead to disclosures from the participant concerning their own involvement in illegal activities or other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Will research involve the sharing of data or confidential information beyond the initial consent given?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Will the anonymity of the participant be compromised at any time during or after the study?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the study likely to induce severe physical harm or psychological distress?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does your research involve tissue samples covered by the Human Tissue Act?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a possibility that the safety of the researcher may be in question (e.g. research in high risk locations or among high risk groups)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**If you have answered yes to any of these questions, please go to section 5 and submit your application to the University RKE Ethics Committee (staff) or to the Departmental Ethics Committee (students)**

**If you have answered no to all of these questions go to section 4.**

**SECTION 4: Ethics Checklist 2****Project description:**

Please provide a brief (no more than 500 words) details in non-technical language of the research aims, the scientific background of the research, the methods that will be used and why it is important to carry out this research. This summary should contain sufficient information to acquaint the Committee with the principal features of the proposal. A copy of the full proposal may be requested if further information is deemed necessary.

Please mark with an "X" as appropriate		YES	NO
1	Does the research involve members of the public in a research capacity (participant research)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2	Is there a risk of over-disclosure that may put the participants at risk or cause them any anxiety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3	Will tissue samples (including blood) be obtained from participants?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4	Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited? (e.g. students at school, members of self-help group?)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5	Is the right to withdraw from the study at any time withheld, or not made explicit?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6	Is there any reason that may make participants feel obliged to participate in the study against their will?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7	Are there any concerns regarding the design of the research project? For example: · where research intrudes into the private sphere or delves into some deeply personal experience; · where the study is concerned with deviance or social control; · where the research deals with things that are sacred to those being studied that they do not wish profaned.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8	Will the research involve administrative or secure data that requires permission from the appropriate authorities before use?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9	Will the research involve respondents to the internet, e.g. social media, or other visual/vocal methods where respondents may be identified?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10	Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11	Are there payments to researchers/participants that may have an impact on the objectivity of the research?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12	Is there any cause for uncertainty as to whether the research will fully comply with the requirements of the Data Protection Act 1998? (See Note 3)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13	Is Disclosure and Barring Service clearance required for your study? (See note 4) *	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14	Does any part of the project breach any codes of practice for ethics in place within the organisation in which the research is taking place?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15	Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants. Will the study involve invasive, intrusive or potentially harmful procedures of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16	Is pain or more than mild discomfort likely to result from the study?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

17	Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life? Will the study involve prolonged or repetitive testing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18	Is a risk assessment required? *	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If you have answered NO TO ALL THE QUESTIONS IN SECTION 4, please sign the declaration section on Page 7 and send it to your Faculty Head of RKE.

If you have answered YES TO ANY OF THE QUESTIONS ABOVE please use the space below to address any ethical concerns. Please make sure you indicate which question(s) you are addressing. Then sign the declaration on Page 8 and send it to your Faculty Head of RKE.

**ADDITIONAL INFORMATION**

*Please use this section to append consent forms, information sheets, questionnaires or any other documentation that may be relevant to your application. Please do this by copying and pasting from your original document.*

*You may also use this section to address any issues not covered in the previous sections.*

## DECLARATION

I understand my responsibilities as principal researcher as outlined in the University of Winchester Research and Knowledge Exchange Ethics Policy.

I declare that the answers above accurately describe the research as presently designed and that a new checklist will be submitted should the research design change in a way which would alter any of the above responses.

Researcher's signature: K Easterling

Date: 15 Dec 2015

Supervisor's signature (for research students only):

Date:

Head of RKE's name (or nominee): Professor Alan Murray

Date: 23 Dec 2015

For taught students (undergraduates, masters) only:

The student has the skills to carry out the proposed research. I undertake to monitor the student's adherence to the relevant research guidelines and codes of practice.

Supervisor's signature:

Date:

Head of Department's signature (or nominee):

Date:



## Appendix 8 Details of the co-authored Published Works

### Submission 1

Type: Government Publication

ORCID ID: 0000-0001-6914-7156

Title of work: Review Body on Doctors' and Dentists' Remuneration (2007) *Thirty-Sixth Report*. Norwich: TSO.

Web Link: Available at:  
[http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB\\_Reports.aspx](http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB_Reports.aspx) [date accessed 21 September 2018].

Abstract: The *Thirty-Sixth Report* makes recommendations for the annual pay increase in 2007-8 for some 175,000 doctors and dentists in the NHS across the UK. There were some concerns for recruitment in some specialities in the recruitment of consultants. There were some grounds for concerns around motivation and morale. The economic and financial background was very difficult as inflation had risen sharply. Employee representatives had requested pay and allowances increases to keep up with rising inflation, whilst the Health Departments and NHS Employers noted funding constraints and spending pressures. Junior Doctors' earnings were decreasing; this was due to the impact of reduced hours in order to comply with the European Working Time Directive by 2009. The independent review was led by the Review Body on Doctors' and Dentists' Remuneration, of which I was a Member.

Indicative Keywords: Pay, Review Body, NHS dentists, NHS doctors.

## Submission 2

Type: Government Publication

ORCID ID: 0000-0001-6914-7156

Title of work: Review Body on Doctors' and Dentists' Remuneration (2008) *Thirty-Seventh Report*. Norwich: TSO.

Web Link: Available at:  
[http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB\\_Reports.aspx](http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB_Reports.aspx) [date accessed 21 September 2018].

Abstract: The *Thirty-Seventh Report* makes recommendations for the annual pay increase in 2008-9 for some 183,000 doctors and dentists in the NHS across the UK. The Review Body did not note any major cause for concern with recruitment and retention. However, it did note concern regarding motivation and morale which was affected by the government's decision to stage the pay award last year; and by the problems surrounding the Medical Application Training Service. A base increase of 2% was recommended to the national salary scales for doctors and dentists. The independent review was led by the Review Body on Doctors' and Dentists' Remuneration, of which I was a Member.

Indicative Keywords: Pay, Review Body, NHS dentists, NHS doctors.

### Submission 3

Type: Government Publication

ORCID ID: 0000-0001-6914-7156

Title of work: Review Body on Doctors' and Dentists' Remuneration (2009) *Thirty-Eighth Report*. Norwich: TSO.

Web Link: Available at:  
[http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB\\_Reports.aspx](http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB_Reports.aspx) [date accessed 21 September 2018].

Abstract: The *Thirty-Eighth Report* makes recommendations for the annual pay increase in 2009-10 for some 187,000 doctors and dentists comprising: 41,000 consultants; 18,000 speciality doctors, associate specialists, staff grades and others; 44,000 general medical practitioners; and 25,000 general dental practitioners in the NHS across the UK. The recommendations were made against the backdrop of an unexpectedly sharp downturn in the economy. The independent review was led by the Review Body on Doctors' and Dentists' Remuneration, of which I was a Member.

Indicative Keywords: Pay, Review Body, NHS dentists, NHS doctors.

#### Submission 4

Type: Government Publication

ORCID ID: 0000-0001-6914-7156

Title of work: Review Body on Doctors' and Dentists' Remuneration (2010) *Thirty-Ninth Report*. Norwich: TSO.

Web Link: Available at:  
[http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB\\_Reports.aspx](http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB_Reports.aspx) [date accessed 21 September 2018].

Abstract: The *Thirty-Ninth Report* makes recommendations for the annual pay increase in 2010-11 for some 194,000 doctors and dentists comprising: 43,000 consultants; 12,000 speciality doctors, associate specialists, staff grades and others; 59,000 doctors and dentists in training; 46,000 general medical practitioners; and 26,000 general dental practitioners in the NHS across the UK. The recommendations were made against a backdrop of a global recession, but the Review Body was not convinced by the government's assertion that senior groups should provide 'leadership in pay restraint'. Different awards were recommended in three groups. The independent review was led by the Review Body on Doctors' and Dentists' Remuneration, of which I was a Member.

Indicative Keywords: Pay, Review Body, NHS doctors

## Submission 5

Type: Government Publication

ORCID ID: 0000-0001-6914-7156

Title of work: Review Body on Doctors' and Dentists' Remuneration (2012a) *Fortieth Report*. Norwich: TSO.

Web Link: Available at:  
[http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB\\_Reports.aspx](http://webarchive.nationalarchives.gov.uk/20130705000836/http://www.ome.uk.com/DDRB_Reports.aspx) [date accessed 21 September 2018].

Abstract: In the June 2010 Budget, the government announced a two year public sector pay freeze from 2011-12 for public sector workers earning in excess of £21,000 per annum on a full-time basis. Accordingly, the *Fortieth Report* does not make recommendations for the annual pay increase for doctors and dentists the NHS across the UK. However, the Review Body continued to monitor recruitment, retention, motivation and other relevant matters within the report. It was invited to make recommendations on dental practice expenses; these are outlined in this report. The independent review was led by the Review Body on Doctors' and Dentists' Remuneration, of which I was a Member.

Indicative Keywords: Pay, Review Body, NHS doctors

## Submission 6

Type: Government Publication

ORCID ID: 0000-0001-6914-7156

Title of work: Review Body on Doctors' and Dentists' Remuneration (2012b)  
*Review of compensation levels, incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.*  
Norwich: TSO.

Web Link: Available at:  
<https://www.gov.uk/government/publications/ddrb-nhs-consultant-compensation-levels-2012> [date accessed 21 September 2018].

Abstract: The review looks at compensation levels and incentive systems and the various Clinical Excellent Award Schemes for NHS consultants in England, Wales, Scotland and Northern Ireland. It was commissioned by Ministers of the four countries of the UK. It concludes that the overall level of compensation for consultants is appropriate. However, it has reservations about the existing schemes which should not be used as a substitution for pay progression, and that awards should be re-earned. The independent review was led by the Review Body on Doctors' and Dentists' Remuneration, of which I was a Member.

Indicative Keywords: Compensation, incentive systems, pay, Review Body, NHS consultants.